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A preliminary analysis of narratives on the impact of training in solution-focused therapy expressed by students having completed a 6-month training course

S. SMITH BA (Hons) BA PGCTLT RMN RNT FHEA

Lecturer, School of Nursing and Midwifery, The Robert Gordon University, Aberdeen, UK

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Correspondence:
S. Smith
Lecturer in Mental Health Nursing
School of Nursing and Midwifery
The Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
UK
E-mail: steve.smith@rgu.ac.uk

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Accessible summary

- Students who participated in a six month training course in SFBT reported significant changes in their relationships with clients.
- They reported increased trust in clients as people, increased confidence in their own professional role, and increased enthusiasm for working with clients.
- Students demonstrated an in-depth knowledge and understanding of solution focused principles and practice, enabling them to own their practice and respond creatively to individual clients.
- It is suggested that substantive training in solution focused brief therapy may help to enhance the professional role and cultural identity of participants, particularly those from a nursing background.

Abstract

Solution-focused brief therapy (SFBT) is a therapeutic approach utilized in a wide variety of settings. Its roots are in systemic and family therapy, and the emphasis in practice is on helping clients identify what their life will be like when they no longer have their problem, and how close they are to experiencing that situation now. The literature suggests that SFBT is at least as effective as other forms of psychotherapy. This pilot-study explored the impact of a training course in SFBT on the nurses who took part. Interviews were carried out with participants ($n = 8$) and narrative accounts were analysed and grouped according to emerging themes. Three major themes were perceived; Trust in clients, Positivity and Confidence, and these were supported by interconnected minor themes relating to the eclectic use of the approach, the use of language within the approach, and the application of SFBT in wider life. It is argued that training in SFBT may have a positive impact on the therapeutic and professional role of nurses, and that further studies are required to explore the impact of SFBT training on the professional and cultural identity of nurses.

Introduction

This pilot-study explored the self-perceived impact of a solution-focused brief therapy (SFBT) training course on the nurses who participated in it. A constructivist approach was utilized to generate participant narratives, which were then thematically analysed in order to generate an inductive understanding of the overall impact of the course. Emergent themes will be explored within this paper and supported by extracts from the accounts given by individual participants.

Background

SFBT is a psychotherapeutic approach based on 'solution-building', as opposed to 'problem-solving' (Iveson 2002). In this respect, it departs from the

traditional psychotherapeutic assumption that a detailed understanding of the presenting problem; its formation, maintenance and resolution, is necessary for therapeutic change to take place. Rather, SFBT is a future-focused, goal-orientated approach, which focuses on *exceptions* (examples of when the 'problem' is not experienced), *solutions* (descriptions of what life will be like when the problem is gone) and the construction of *scales* to measure the client's progress towards their solution (Trepper *et al.* 2006). The model was developed by a team of family therapists working at the Brief Family Therapy Centre (BFTC) in Milwaukee, Wisconsin in the early 1980s, and drew on the work of Milton Erickson, John Weakland and his colleagues at the Brief Therapy Centre, at the Mental Research Institute in Palo Alto, California, and Mara Selvini-Palazzoli and her colleagues at the Centre for the Study of the Family in Milan (de Shazer *et al.* 1986). In their seminal paper, 'Brief Therapy: Focused Solution Development', de Shazer and his colleagues concluded that clients already knew what to do to solve their problems; they just didn't know that they knew. Thus, it was the therapist's role, they argued, to help clients 'construct for themselves a new use for knowledge they already have' (p. 220).

Since 1986, SFBT has developed beyond its family therapy roots and has been utilized in therapeutic fields as diverse as couples therapy, treatment of sexual abuse, adult mental health, substance misuse, sex therapy, eating disorders, treatment in schizophrenia, individual counselling work, group work and self-help books, as well as non-therapeutic settings such as social care agencies, educational settings, prison populations and business systems (Iveson 2002, Trepper *et al.* 2006, Walsh 2006). In the first decade post 1986, although a number of descriptive papers were published (Sykes-Wylie 1990, Webster 1990, Wilgosh *et al.* 1993, 1994, Montgomery & Webster 1994, Iveson 1995, Wilgosh & Hawkes 1995, Hillyer 1996, Sandeman 1997), there was little research literature produced. de Shazer argued in 1997 that the research base of SFBT was one of 'naturalistic inquiry' based on the research question, 'What do clients and therapists do together that is useful?' (de Shazer & Berg 1997, p. 122); however, he acknowledged that since its development in the early 1980s, 'research into the approach . . . has been minimal' (p. 121).

However, the past decade has seen a rapid growth in the research literature surrounding SFBT. In a review of the literature, Gingerich & Eisengart (2000) identified 15 controlled outcome studies of SFBT, although they found only five of these studies met their criteria for 'well controlled' studies. Of these five studies, four found SFBT to be better than a 'no treatment' control, and one found it comparable with an alternative known intervention. Of the remaining 10 studies, described as 'moderately or poorly controlled', outcomes were 'consistent with a hypothesis of SFBT effectiveness' (p. 477). Kim (2008) noted that in the 8 years following Gingerich and Eisengart's review there had been a growth in the number of outcome studies reported in peer-reviewed journals (p. 108), and conducted a meta-analysis of the literature, in which 22 studies met his robust, and clearly defined, entry criteria. Meta-analysis of the literature found small but positive effects favouring the SFBT group on the outcome measures. In the nursing literature, Bowles *et al.* (2001) evaluated the impact of solution-focused communication training on nurses' communication skills. They concluded that SFBT may be a useful approach to training nurses in communication skills as it was congruent with nursing values of empowerment, and promoting patient responsibility and participation in care. Stevenson *et al.* (2003) carried out a multi-faceted study employing a triangulated data collection design to assess the impact of a SFBT training course on nurses and clients in an acute psychiatric setting. Twenty-three nurses attended a two and a half-day course (20 h) delivered as three cohorts over 3 months. The authors drew no conclusions from the study beyond stating that the evidence suggests that both the nurses and their clients found the approach useful. Hosany *et al.* (2007) reported on a pilot-study into the outcomes of training a group of mental health nurses in solution-focused therapy techniques. Thirty-six nurses, all employed in acute psychiatric inpatient units within a UK National Health Service (NHS) mental health trust, undertook a 2-day training course in solution-focused therapy techniques. The authors report a significant positive shift in terms of participants reducing their focus on clients' problems ($P = 0.001$), utilizing a 'preferred future/miracle' question with clients ($P = 0.002$), utilizing 'exception/achievement' questions with clients ($P = 0.013$), and the use of scaling questions with clients ($P = 0.008$). They also report a positive, but non-significant, shift in terms of focusing on clients' current strengths and resources, personal goals, finding solutions with clients and the use of coping questions.

It can be seen that, while research into SFBT has increased significantly in this decade, there remain very few studies carried out from a nursing perspective. Of the literature which does address this aspect of training; the focus is directed to the impact on nurses' clinical practice and interactions with clients, and on the outcomes of training nurses in very short introductory training courses; typically less than 20 h direct contact. None of the literature addresses the impact of longer, more substantive training courses, nor does it address the wider impact of training on nurses' professional and cultural identity.

Study design

The current study aimed to address this imbalance by exploring the impact nurses believed participating in a 6-month training course in SFBT had had on them as individuals and as practitioners. The study set out to answer the questions:

1. What impact do former students believe the SFBT course has had on their own practice?
2. What impact has the course had on the constructs through which they view the people using their services?
3. What impact has it had on their working relationships with colleagues?

Participants in the study were recruited from students who had undertaken a 6-month training course in SFBT. The course was accredited with 15 credits at Scottish Credit and Qualifications Framework level 9 (equivalent to the National Qualifications Framework level H), and involved 60 h face-to-face teaching and a further 90 h self-directed learning. Students were assessed via a practical, skills-based assessment and a written assignment. Ten students completed the course, and eight (80%) agreed to participate in the study. Most of the participants were mental health nurses; two were CPNs, two were in specialist mental health services, one was based in an acute inpatient setting, two were Primary Care Mental Health Workers, and one was a Health Visitor.

An interview guide was developed as an aid to data collection. This tool was adapted from the European Brief Therapy Association (EBTA) research definition for a solution-focused therapy interview (Beyebach 2000) in order that the research process would mirror the constructivist perspective of solution-focused therapy, enabling the interviewer to adopt a theoretical stance congruent with the practice being investigated. Minimal changes to the EBTA tool, in relation to the different terminology used in a therapeutic setting to a research setting, were undertaken; however, the design of the tool is such that no significant changes were required. In general terms, the interviewer adopted a respectful and cooperative stance, working from within the interviewees' frame of reference to co-construct a narrative account of 'changes' which the interviewee had experienced (in the specific context of the course and their clinical practice) since undertaking the course. As a minimum, this was seen to include:

- beginning the interview by asking 'What has changed since you completed this solution focused therapy training course?';
- asking and following up on Scaling Questions;
- complimenting the interviewee at the end of the interview.

In the event, the Scaling Question ('on a scale, where 10 stands for you having got everything that you expected to get from the course and 0 stands for you not having got any of what you expected from the course, where would you put yourself right now?') provided little useful data. A mean score of 9.8 (range = 8–12, mode = 10) demonstrated a high level of satisfaction, but added little to the understanding of what would have enhanced that experience further. Ending the interview by complementing the participant was seen as an ethically sound and theoretically congruent way of thanking the interviewee for participating.

A schematic representation of the interview process can be seen in Fig. 1.

Interviews were audio taped, and these taped accounts then became the raw data for analysis. The purpose here was not to undertake a holistic analysis of each account as an emplotted narrative, but to provide a categorical analysis (Lieblich *et al.* 1998) in which short sections of text are extracted and subjected to content analysis (Mischler 1995) in order to explore the meaning inherent in the specific episode for the narrator. In order to do this, sections of text were removed from the transcript of each narrative and parsed into the form of poetic stanzas. Riessman (1993) argues that this approach is particularly suitable where, as was the case here, there is little formal emplottment, few narrative clauses, and the locus of action is in the present tense. These stanzas were then thematically coded and analysed to identify key events in the narrative and the significance the participant placed on that, i.e. 'what happened and what it meant' (Polkinghorne 1995). The parsing of text into poetic stanzas results in the removal of extraneous material, conversational utterances and the like, leaving only the intense, detailed meaning of the participant's experience in an accessible format; these stanzas were then returned to the participant for comment and validation. Given the cooperative, co-constructionist stance of both solution-focused therapy and the study, it

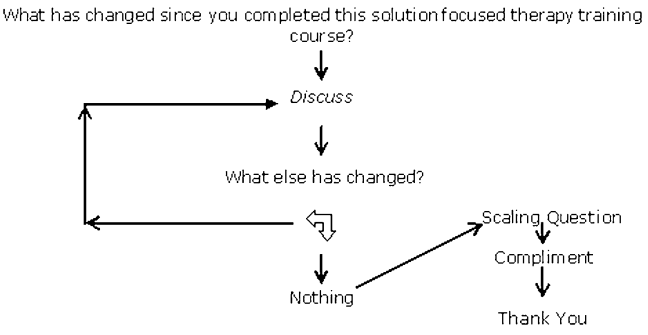

Figure 1
Schematic representation of the interview process

Table 1
Process of data collection and analysis

Stage 1	Individual interviews
Stage 2	Transcription of interviews
Stage 3	Extraction of key sections of text and parsing into poetic stanzas
Stage 4	Content analysis and thematic categorization of stanzas
Stage 5	Respondent validation
Stage 6	Comparison and grouping of themes across narratives
Stage 7	Creation of a thematic taxonomy based on participant's experiences

was decided that participants would have the privileged interpretation of their own narrative and any contested material would be amended in light of respondent feedback or, if that was not possible, removed. In the event, all eight participants agreed with the synthesis of their account. Comparison of all narratives was then carried out to inductively create thematic groupings from the data. A graphic representation of the data collection and analysis process can be seen in Table 1.

Results

Three major themes emerged from the analysis of the data. These were: 'trust in clients', 'positivity' and 'confidence'; this last theme being demonstrated as confidence in the therapeutic process, confidence in the participant's ability to conduct a SFBT interview, and confidence in the participant's sense of self. Each of the themes expressed by participants will be explored in greater detail below; the statements quoted are extracts from participants' narratives.

Trust in clients

The first of the three major themes to emerge from participants narratives was that they had moved to a position where they had greater trust in the clients they worked with. They described an increased tendency to work with the client, to listen to and learn from the client what was important in the client's life, and to have a more tangible faith in the client's ability to overcome the presenting problem.

> I strive to learn from them (clients); what works for them, and I think this has strengthened my belief in them. (Participant 1)

The majority of participants expressed a belief that this change was at odds with the prevailing system of care, and positioned themselves in partnership with the client. Although their previous position was not clearly defined; this new found sense of alliance would suggest that participants were working in a more collaborative manner with clients, and had found a genuine respect for the strengths that clients possess.

> The focus on the client, in their terms. It's the client who holds the keys. That's something I can say to managers: 'It's the client who knows what's going to help them.' (Participant 5)

Positivity

This second theme relates to the enthusiasm and positive outlook expressed by participants for working with clients. Despite interviews being carried out more than 8 months after the taught component of the course was completed, and almost 3 months after most participants had submitted their final assignments, participants spoke (often in surprised terms) of the success they had experienced in working with clients, and their renewed enthusiasm for nursing generally.

> Success builds on success. The first time you try it and you get a success, you think, 'Wow!' (Participant 1)
>
> Now I want the difficult cases. I'm thinking, 'How are they still alive?' I'm far more interested in people. (Participant 6)

This enthusiasm for clinical work was often related to the experience of looking for 'what's working' in clients lives. Participants found that by focusing on the positive aspects of clients experience, rather than the problems they brought with them, they were not only able to help clients construct solutions in their own lives, but they found the clinical experience more rewarding. This experience, reinforced by the positive outcomes reported by clients, appeared to engender in participants a much more positive outlook towards clinical working than that to which they had become used.

> Positivity. It changes everything from negative to positive. Taking the mirror image. (Participant 4)

Confidence

In general, along with the two themes reported above, participants displayed a sense of confidence which extended beyond direct work with clients. Some of this confidence was directed towards a new found understanding of SFBT theory and practice. Many participants had attended previous SFBT training workshops delivered over 1 or 2 days; these had generated an interest to know more about the approach, but participants had been reluctant to utilize an approach in clinical practice without a deeper knowledge of its theoretical underpinnings.

> So having been on a course and hearing the rationale behind it has increased my confidence in the ability of SFT to be a valid approach. (Participant 2)

In the evidence-based culture of contemporary practice, the knowledge that SFBT has a rigorous scientific evidence base, and a detailed knowledge of that evidence base, had enabled participants to have an increased level of confidence in their ability to include SFBT in their clinical practice. This confidence in the approach *per se*, had allowed many participants to develop confidence in their own ability to apply the principles of SFBT in their clinical work.

> It's changed my clinical practice, it gives direction to assessment. Helps to avoid *red herrings*. (Participant 4)

Many participants related a sense of having been unstructured in their previous work; of groping to find ways to solve client's problems, and relying on their own personal strengths to generate answers for clients. This was in contrast to their experience since completing the course, which enabled them to remain focused on helping clients find solutions, and to avoid the pitfalls of dwelling on past problems and failures.

> The confidence it's given me, all over. I wouldn't have done this interview before. I couldn't have. I'm confident in doing solution focused. I love doing it. You don't do a full session. You do bits of it. Everywhere. (Participant 8)

In addition to increased confidence in SFBT practice, many participants also reported feeling more confident in themselves as both practitioners, and as people. The ability to clearly identify that they were helping people, and to be able to explain how they were doing so, appeared to generate in many participants a new found sense of 'making a difference'. Being part of a therapeutic team, many participants reported previously having had no clear sense of their therapeutic role. There appeared to be a sense that they were now able to offer a distinctive psychological therapy which reflected their professional beliefs and assumptions.

> My model was that of psychiatric nursing; the role of a psychiatric nurse. I didn't have something to hang my hat on. (Participant 6)
>
> It helped my confidence; I felt I had something to offer. Something different. (Participant 3)
>
> It's made me a nicer nurse! (Participant 7)

Discussion

Taken together, the themes that emerge across the data suggest that completion of the SFBT course had a significant impact on participants. They reflect the enthusiasm for working with clients that participants found as a result of successfully helping clients find their own solutions. It is interesting that many participants reflected on realignment in their clinical practice: a shift of allegiance from 'the team', where the client was seen largely as a problem in their own right; to allegiance to the client, where the client is perceived as the person *with* the problem, and the team as an obstacle to the client finding their solution. There was a sense expressed by many participants that this approach enabled them to do what it was they had come into nursing to do in the first place. This perception would be in keeping with the theoretical position outlined by Webster (1990), who argued that the principles of SFBT were congruent with both traditional nursing values, and feminist principles of equality and healing. Arguably, the three themes reflect different facets of a shared experience: the theoretical knowledge and clinical skills acquired on the course enabled participants to change the way they worked with clients, resulting in greater engagement with the client as a person, and improved clinical outcomes. These positive outcomes then act as a feedback loop, providing positive reinforcement to the participant in regard to the applicability of the change in practice, their ability to deliver it appropriately, and their relationship with clients.

Both the eclectic use of the approach by participants, and their understanding of the use of language within the approach, reflect the technique Tomm (1987) has called Interventive Interviewing.

> Interventive interviewing refers to an orientation in which everything an interviewer does and says, and does not do and does not say, is thought of as an intervention that could be therapeutic, nontherapeutic or counter-therapeutic. (Tomm 1987, p. 4)

Thus, the realization that everything they say and do can have some therapeutic value, for good or ill, coupled with a framework to enable them to help create positive change in client's lives, has lead to a greater awareness of the language they use in some participants, and the increased ability to use that language therapeutically in ad hoc, informal settings in others. Additionally, the use some participants have made of SFBT approaches in their own life is congruent with the systemic philosophy underpinning SFBT theory, and arguably places SFBT in the realm of 'life skill training' or 'adult education', as much as the 'psychotherapy' domain in which participants first encountered it.

A number of methodological limitations are apparent due to the small scale of this pilot-study. Clearly, no generalizations can be made from the findings of this study to a larger population. The outcomes reported here reflect the stories of one cohort of one training course; however, its design allows some confidence to be placed in the thematic analysis of participant's narrative accounts of their experience. Additionally, as with all self-selecting interview designs, there is a potential for positive bias within the study sample. This potential is, perhaps, mitigated by the high response level (80%) within the total population, defined as those course participants who had completed the course at the time of the study. Completion of the course

was taken to mean that the participant had submitted all relevant course work, this had been internally assessed by the course team, and feedback had been sent indicating that the participant had provisionally passed the course. An alternative definition of completion was that the participant had withdrawn from or failed to successfully complete the course. In the event, all potential participants had successfully completed the course, and there were no obvious differences in training, or role, of the course completers who did not participate in the study.

Conclusions

It can be seen that participating in the 6-month training course had a significant impact on those former students who took part in the study. Having completed the course, they reported changes in the way they viewed clients, changes in the process and content of their clinical work, and a marked change in their enthusiasm for working with clients. They also demonstrated the acquisition of a depth of knowledge and understanding of the philosophy and theory underpinning the approach, enabling many of them to take ownership of their SFBT practice at a level beyond simple technical competence. While there are now many empirical studies examining the clinical effectiveness of SFBT, there have been few studies into the professional and cultural outcomes of training nurses in SFBT. This small pilot-study would suggest that SFBT may have a positive role to play in enhancing the therapeutic and professional identity of nurses; and it is suggested that further research in this field would be of value. The results of a larger study, following on from this pilot-study, will be reported in due course.

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