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BECOMING:

**An Analysis Of Narratives Describing The
Experiences Of Nurses Who Have
Undertaken Training In Solution Focused
Brief Therapy.**

Stephen W. Smith

A thesis submitted in partial fulfilment of the requirements of
The Robert Gordon University for the degree of Doctor of Philosophy

May 2015

Abstract

Stephen W. Smith

Degree of Doctor of Philosophy

Becoming: An analysis of narratives describing the experiences of nurses who have undertaken training in solution focused brief therapy.

This thesis is a study of the experiences of nurses who have undertaken training in Solution Focused Brief Therapy (SFBT). While the clinical outcomes of using SFBT, and other psychological therapies, to treat clients have been the subject of much research, the outcomes of training therapists to use SFBT has been relatively unexplored. It is, therefore, my intention to address, in part, this uncharted area of practice.

Utilising a mixed methodology, the study is divided into two Stages. In Stage I, an original Solution Focused (SF) methodology is developed and used to conduct individual interviews with twenty participants. Interviews are transcribed and treated as narrative texts, and are then subjected to multi-factored analysis enabling the synthesis of a 'group narrative' and the construction of a typology of experience. In Stage II, I conduct further in-depth interviews with three of the original participants and utilise a hermeneutic methodology, drawing on the work of Hans-Georg Gadamer, to engage with the texts generated from these interviews. The texts are explored thematically, and through the nursing metaparadigm of Jacqueline Fawcett, and are compared with a metaparadigm of SF practice.

The research suggests that training in SFBT can have a profound effect on the clinical practice, and professional identity, of nurses, and that this is related to the paradigm of nursing which informs their practice. Where the nursing paradigm is of the dominant 'assessment and delivery of care needs' modality, SFBT training has little to offer the

nurse; however, where the nursing paradigm reflects an 'interpersonal, dynamic' modality based on shared relationships, training in SFBT can be a transformative experience for the nurse.

This research makes an original contribution to the field of SFBT and to our understanding of the relationship between SFBT and nursing. Building on the work of earlier scholars, it argues that SFBT is congruent with some nursing paradigms, and not all nursing paradigms as previously suggested. It also advances our understanding of how the scope and field of SF practice may be delineated.

Keywords: Solution focused brief therapy, nurses, training, personal experience, methodology, narratives, hermeneutic phenomenology, metaparadigm of nursing, solution focused metaparadigm, ontology.

Acknowledgments

As Donne said, "No man is an island"; I would like to take this opportunity to acknowledge the veritable continental land-mass of colleagues and friends who have supported me through this work.

I would first of all like to thank all of my colleagues and former students who participated in this study, without whom there would have been no project. In particular, I would like to express my great respect and appreciation to the three nurses who participated in Stage II, who are called here Dawn, Judy and Lesley; they know who they are – thank you. I would also like to thank my colleague, Peter Hammond, for so readily giving his time and enthusiasm in participating as Research Assistant in the early stages of the project.

I would like to thank my supervisory team, in particular my senior supervisor, Dr Colin Macduff, who has always been the most supportive, informative, challenging and encouraging of critical friends; and also my grateful thanks to Dr Mary Addo, Dr John Love, Dr John Gass and Dr Pete Wimpenny. I would also like to thank those mentors, colleagues and role-models who have been a source of inspiration to me over the years; Dr Sally Lawton, Dr Bernice West, Prof Brian Webster, Dr Mark McKergow, the late Dr Andy McKie and my lifelong friend and collaborator, Graham Buchanan. I would also like to express my sincere thanks to my boss, Dr Sheelagh Martindale, whose support and enthusiasm has been invaluable.

I would, most of all, like to thank my family; my wife, Kate, and my children, Keenan, Emily and Sarah, for being the foundation upon which everything else is built, and for never doubting I could do it.

Finally; my parents: my dad, William Galt Nairn Smith, and my late mother, Mary Smith - thank you.

"Gyatei, Gyatei, Haragyatei, Hara Sōgyatei, Bodi Sowakei".

(Going, going, going on beyond, always going on beyond, always seeking wisdom)

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Preface: My Story

i. Narratives

Several years ago, when my son was at primary school, we were sitting round the table after dinner, and he was telling the rest of the family what he had done in school that day. He told us about a project on World War II his class were doing.

“The teacher asked if anyone knew who Winston Churchill was”, he said, “and I put my hand up. I said he was a bad man who wanted to shoot the miners.”

I was quite surprised by this, and asked him where he got that idea from.

“You told me! You said that your granda was a miner, and he didn’t like Winston Churchill because he said, ‘put the miners up against a wall and shoot them’, when he was on strike.”

It was true! My grandfather had been a miner, and he had told that story about Winston Churchill. However, he’d never told the story to me, and as far as I was aware, I’d never expressly told it to my son. And yet, the story had passed through four generations of my family; my mother had heard her father talking about it, I had heard her talking about it, and my son had heard me talking about it. It brought home to me, in a very clear way, the power of narratives to create reality, and to survive. In researching this chapter, it has become apparent to me that the story, as a whole, is probably untrue. Churchill’s biographer, Martin Gilbert (1991) makes no mention of the episode, nor does Roy Jenkins (2001), although the latter does describe Churchill’s general demeanour during the General Strike as being of “the utmost bellicosity” (p408), noting his desire to put “tanks

with machine guns" (p409) on the streets of London at the height of the dispute.

Jenkins does, though, refer to Churchill's part in the 'Tonypany Riots' of 1910, where Churchill was believed by the mining community to have ordered troops to intervene in the South Wales Miners' Federation strike in Rhondda. Jenkins defends Churchill against this allegation, and states:

"On any objective analysis it is difficult to fault Churchill in the Rhondda for any sin of aggression or vindictiveness towards labour. Indeed at the time he was more criticized from the opposite direction."

(p.199)

He goes on, though, to recognise that the incident soured Churchill's relationship with the mining community for the rest of his life, and this is presumably the source of my grandfather's dislike of the former Home Secretary (and, of course, Prime Minister).

Whether or not Winston Churchill spoke those words, however, is largely immaterial; what remains is that a story *about* Winston Churchill survived in my family for over eighty years, without being consciously told or retold. It became, in a sense, part of the narrative of my family - one small part of our heritage, of how we see ourselves, of our past and, by extension, of our future.

As a child adopted in infancy, the earliest story I can remember is that of the Mummy and Daddy who didn't have a baby of their own; so they went to the Big House where the babies who didn't have a Mummy or Daddy were looked after. They asked there if they could have a baby, and were told they could look around and choose a baby to take home. So they looked around at all the babies and, after a while they saw one baby that was just the baby for them, and they chose that baby. They took the baby home and that became their baby; but, this was no ordinary baby, because this baby was *specially chosen*. The story would always end with me being asked, "And do you know who that specially chosen baby is?" to which I would enthusiastically reply, "Me!" It was always a source of amazement to me, to discover that, at only eighteen months old, I was already in a story. Thus, stories formed the earliest part of my identity and my experience of the world. In this, I suspect I'm no different from most people.

Polkinghorne (2007) notes that:

"Stories are ubiquitous, appearing as historical accounts, as fictional novels, as fairy tales, as autobiographies, and other genres. Stories are also told by people about themselves and about others as part of their everyday conversations".

(p.471)

Furthermore, Lieblich and Josselson (2012) state that narratives are one of the means by which people "make sense of their experiences and locate themselves in society and in time" (p.203). For me, stories are the building blocks of who we are; they combine in multiple ways to define our past, our present, and our future. Building on the 'specially chosen' story, my early identity incorporated stories of my

own babyhood (leaning out of my pram to see the flower on the side, and falling out), my parent's childhood (war time air-raids and being evacuated to Clackmannan and Kilmarnock respectively), and a dynasty of family patriarchs (and matriarchs) going back through my Grandfather (who had been a ploughboy on Sir Alexander Fleming's family farm), Great Grandfather (who had 'wafted his tea with his bunnet' at my parent's wedding), Great-Great Granny Nairn, and beyond to Captain Hohner, the German Sea-Captain who settled in Ayrshire in the early-mid nineteenth century and appears to have started the whole thing off. These are the stories that I wasn't necessarily told, but heard, as I grew up. In a sense, in the absence of a 'blood-line', these are the 'narrative line' that define and bond my family today. Of course, I'm not unique in this respect, but the point I wish to convey here is that, for me, narratives have always been the thing that defines who someone is.

ii. Zen Buddhism

As a child I had a fairly typical Scottish, Presbyterian upbringing; my Father was a Kirk Elder (as was my Mother in later years) I attended Sunday School and Church, sometimes both on the same day. However, from the age of twelve or so I began to grow away from the Church and at fourteen I discovered Buddhism. I was introduced to Buddhism through Religious Education classes at Secondary School, and my experience was less a *decision* ('That's what I'll become') than a *discovery* ('Oh, that's what I am'). I was immediately attracted by the Buddhist idea that there is 'only one thing': Buddha Nature, the historical Buddha, Buddhist practitioner, all living beings, everything; all different manifestations of 'one thing'. This, of course, isn't unique to Buddhism, and I found similar pantheistic ideas in the work of Baruch Spinoza when I came across it many years later. One thing I was cautious of was the cultural baggage of Buddhism; the external

attributes that define Tibetan Buddhism or Indian Buddhism, the way in which a Western convert to Buddhism might take on an Indian name, or adopt the manner of a Tibetan monk and so forth. I had no ambition to become someone else; I didn't want to 'fit' into a new religion, what I wanted was a faith that could accommodate me. For many years I thought of myself as a 'Buddo-Christian', or a 'Christo-Buddhist'; neither one nor the other, moving back and forth between the two and making connections between what I learned and what I believed. I was in my mid-thirties when I discovered Soto Zen, one of two disciplines in Zen Buddhism. I had heard of Rinzi Zen (although I had only perceived of it as a generic 'Zen') many years previously and had avoided it as the 'Japanese Buddhism' of *koans* and paradoxical puzzles ('What is the sound of one hand clapping?' and so forth); I had no more desire to adopt the cultural baggage of Japanese Buddhism than I had to adopt that of the Indian or Tibetan traditions. However, Soto Zen appeared to me to dispense with the cultural associations of its Far East origins and to offer a minimalistic framework for simple 'sitting meditation'. It may not be a coincidence that my teacher of Soto Zen is a Westerner, teaching in a Western idiom. However, here was a practice that didn't require me to believe in a pantheon of new deities, in gurus who could leap across mountain ranges on the back of flying tigers, or in reincarnated souls who continued from life to life; here was something where all I had to do was sit still and let go of my attachment to how things *should be*, in order to appreciate the experience of how things *are*. And I didn't have to take anybody's word for it, least of all The Buddha; I was expected to test the hypothesis for myself.

So for the past fifteen years I have considered myself to be a Zen Buddhist. Some of the things I have taken from that belief are the understanding that there is 'only one thing' and it is constantly changing. At a very functional level; the 'thing' that was a *potato* yesterday is *me* today, and is *waste* tomorrow. The notion of *I* is fixed

in a given point in time, and has changed before I can even register it. This has implications, not only for Solution Focused Brief Therapy (SFBT), but as I have discovered through this research, is echoed in Heidegger's phenomenology.

In terms of SFBT, the assumption that change is on-going is, arguably, the central tenet of the approach. Client's problems are typically seen as being fixed; 'it happens all the time'; De Shazer and colleagues highlighted this in 1986 when they formed a distinction between *difficulties* and *complaints*.

"Difficulties are the one damn thing after another of everyday life ... which clients frequently call "problems." These include, but are not limited to, such things as the car not starting, a pickle jar not opening, a husband and wife arguing now and then, and a child wetting the bed. Complaints consist of a difficulty and a recurring, ineffective attempt to overcome that difficulty, and/or a difficulty plus the perception on the part of the client that the situation *is static and nothing is changing*; that is, one damn thing after another becomes the same damn thing over and over."
(Emphasis mine)

(p.210)

SFBT, being a change oriented therapeutic approach, makes the assumption that this cannot be true; that although this 'same damn thing' happens often, it doesn't happen all the time, there must be an exception. SFBT then becomes, in a sense, the search for the exception, and how to expand upon it.

In terms of Heidegger's phenomenology, I have come to recognise parallels between my understanding of the concept of 'self' being an illusion fixed in a given moment, and Heidegger's central theory of the inter-dependence of 'Being' and 'time'. In both, 'Being' is a transitory experience in the context of linear 'time', and 'what we are' is, arguably, less important than 'what we are becoming'. Heidegger saw Being as a oneness; there was no distinction between the Being of an Indian elephant and the Being of a chemical process on Mars, and the only difference between Being in these contexts and Being in a human context is that it is human beings who pose the question, 'What is Being?' (Krell, 1993)

The experience of Being (or the one who experiences Being), as I understand it, was conceptualised by Heidegger as *Dasein* (being-in-the-world), a subjective state inherently connected to the context in which it exists, and inherently connected to the other subjects it exists alongside.

"There is no time at which we don't exist as constituted in relation to others. That is why Heidegger says that *Dasein* is equally-originally *Mitsein* - to exist is to exist-with."

(Vessy, 2005)

This intersubjectivity between beings in the greater experience of Being reflects, for me, something of the nature of the Zen 'one thing'; a series of interconnected beings, categorised into subsuming categories until a point is reached where the only category is Being (the essential God of Spinoza's philosophy, or Buddha Nature of Zen). My point here is not to argue for some unifying theory of 'life, the universe and everything', but to recognise the links between my

beliefs, and my more recent experience of research, and in doing so make explicit the coherence in my thesis while avoiding the 'thrall of my prejudices' (Gadamer, 1979) in arriving at it.

iii. Mental Health Nursing

In 1980 I left home to train as a Mental Health Nurse, or Psychiatric Nurse as the terminology was then. Again, this was less a decision than a discovery of something that 'fitted me'. At the age of seventeen I had little practical idea of what I wanted to be in life; I had many vague ideas of what I wanted to *do*, but none of that seemed to translate into a career path or something that I could *be*. The decision to become a Mental Health Nurse took less than a minute and was largely based on the fact that one of my oldest friends had applied.

"I'm going to be a Psyche Nurse", he told me as we walked across the Abronhill - Kildrum Bridge, in Cumbernauld.

"What's that; mad axe-men and stuff?" I asked, reflecting my limited insight into psychiatry, gained largely from cinema and the tabloid press.

"No; it's more like sitting talking to a bunch of guys with problems, and helping them work them out".

"Oh; like 'therapy'?" I asked.

"Yeah, I suppose so."

And that-was-that! By the time we had arrived at the other end of the bridge, I had decided to become a Mental Health Nurse. There was though, a clear distinction in my mind between *psychiatry* and *therapy*; the former was oppressive, controlling and conformist,

images of Nurse Ratched in 'One Flew Over The Cuckoo's Nest' came immediately to mind, the latter was liberating, empowering and liberal, I was sure I'd seen Elliott Gould play a therapist in a film at some point. Clearly, both stereotypical views were based on narratives I had experienced in many different contexts up until that point, and looking back, reflect a Heideggerian dichotomy between working for *Das Man* and working for *Authentication*. More importantly (as a seventeen year-old) one was 'cool' in a way the other wasn't.

As part of my research process, I was interviewed by one of my supervisors using the same anchor questions I used to interview participants in Stage II of my project. Several reasons were posited by my interviewer as to why I may have wanted to become a Mental Health Nurse; had there been a vocational calling, a political ideal, a social awareness he asked. At the time of the interview I said I didn't think so; however, having had time to consider the question, his assumptions may have been more astute than I realised. While knowing something of what I wanted to do, and considering what I wanted to be, I had, at various stages, thought of a vocational calling. The idea (or at least, *my* idea) of the contemplative monastic life was appealing in some respects; it appeared peaceful, non-materialistic, ordered and at-one-with-the-world. However, as a lapsing Presbyterian still a long way from Zen Buddhism, there wasn't a pathway into the monastic life and so, that road was closed. Equally, from a political and social awareness perspective; I had grown up in an atmosphere of Marxist-Socialism and prized the notion of social equality. I wanted to do something 'useful' in life, and had toyed with ideas of journalism or law; the former in the sense of 'an investigative reporter' in the mould of Bob Woodward or Carl Bernstein (I was a socially aware thirteen year-old when 'All The President's Men' was released), the latter in the form of Atticus Finch, or similar defender of justice. Not having achieved the necessary qualifications however, both of these pathways were also closed, and I had to settle for eight

years as a Trade Union activist, representing staff groups in the difficult years of NHS change in the 1980's. I had also considered volunteering for the Simon Community, who I knew delivered food to homeless people in Glasgow (that was really *all* I knew about them); however, the need to have a paying-job put an end to that pathway. None of these were particularly well thought through ideas; but, looking back, they say something about what I wanted to be, and what I thought training as a Mental Health Nurse might enable me to do.

In the event, Mental Health Nursing has allowed me to achieve many of these ambitions. In particular, beginning in 1989 when I was introduced to Semi-Interpretive Group Analytic Therapy, I have been able to work 'in therapy'. This developed in the early 1990's when I discovered SFBT, a therapeutic approach where I could finally sit "talking to a bunch of guys with problems ... helping them work them out"; the emphasis being on *helping them work them out* as opposed to *working them out for them*. Fairly or unfairly, SFBT has tended to be portrayed (at least by SFBT practitioners) as being at the 'liberating, empowering and liberal' end of the therapy spectrum; and while I suspect few therapists actively describe their chosen modality as 'oppressive, controlling and conformist', I would clearly share this view of SFBT.

These then are the three things which I would say defined me by the age of twenty, and have shaped who I have become (and am becoming) since.

- I believe that we make sense of our world, and our place in it, through the narratives we tell ourselves and each other.
- I am a practising Buddhist in the Soto Zen tradition.

- I am a Mental Health Nurse, the key feature of which is 'helping people to work through their own problems'

These things also shape the interpretations I have made on the data I have collected, they shape the data collection process, they shape the focus of my research; I am interested, as a Mental Health Nurse, in the impact training in SFBT has had on other nurses, I am exploring this through an analysis of the narratives these nurses tell me, and I am basing my methodology on a number of assumptions congruent with my Zen Buddhist beliefs. There are, of course, many other things that define who I am as a researcher. I'm a man, I'm Scottish, I'm white, I'm a husband and father, as a Nurse I'm predominately in academic practice, I live on a farm, I like old cars ... the list goes on and on; what is important is the recognition that I'm an individual (in a given point in time). I'm Steve Smith, and that makes me different in many ways from the people I have interviewed (and equally from the people who will read my thesis); therefore, I bring my own assumptions, beliefs and expectations, my own prejudices to the project and these are the lens through which I see the endeavour.

Chapter 1: Background

1.0 Structure of the Thesis

In this thesis I shall explore the question, “What is the experience of nurses who have undertaken training in solution focused brief therapy?” In the preface I have provided a detailed account of the factors that helped define and shape the person that I am today; that is, the person who has carried out this research project. The importance and relevance of this will become clear in the context of Gadamer’s hermeneutic phenomenology. In Chapter One I shall set the context in which the above research question is posed. I shall argue that the appropriate focus of clinical outcome research, in psychotherapy, should be the practitioner rather than the modality and, in light of that, justify the purpose of the research project. The literature on SFBT will be reviewed in Chapter Two, an overview will be provided prior to a detailed exploration in relation to nursing training outcomes. This will set something of the clinical context of the study and will help familiarise the uninitiated reader to some of the key concepts involved in the practice.

The methodology employed in this study is divided into two sections; conveniently referred to as Stage I and Stage II. In Stage I an original SF methodology is employed, and the development of this methodology is discussed in Chapter Three. Stage II employs a (relatively) more traditional methodology, that mentioned above, of Hans-Georg Gadamer, and the background to this is also discussed in Chapter Three. The specific design of each stage is then discussed in Chapter Four; the process of developing the design for Stage I, as it evolved over time is explored, and the relevance of key questions is

analysed. A similar analysis of the key questions employed in Stage II is also provided.

Stage I of the project involved interviewing 20 participants, and a multi-factored analysis of the narrative texts generated by these interviews is provided in Chapter Five. Analysis of these narratives enabled the creation of a composite 'group narrative' and the construction of a typology of experience; this typology suggested a link between the quality of the participants' experience of training and the nature of their work environment. While most participants reported a very positive experience of training in SFBT, those who worked in a team setting had a less positive experience than those who worked in an autonomous role. This then informed the selection of participants in Stage II, where three participants with experience in both types of working were selected for further interview. Prior to addressing the data from Stage II, Chapter Six discusses the implications of the training experience for the wider health and social care community. I argue that SFBT provides a framework through which nurses can achieve a strong, independent, professional identity and engage with clients in a collaborative therapeutic manner, offering them renewed enthusiasm and commitment to clinical practice.

An interpretation of the texts generated by each of these interviews is provided in each of Chapters Seven, Eight and Nine. Chapter Seven provides an overview of the process employed in the interpretation of texts and then it, and the following two chapters, offer a detailed understanding of the texts. In each case a thematic analysis of the text is provided, followed by my interpretation of the meaning being conveyed to me in reading the text. Chapter Ten begins by reviewing the argument so far, and recognises that the link suggested by the typology in Stage I should be dismissed. However, by reading the texts through the contextual lens of Fawcett's (1984, 2005)

metaparadigm of nursing, I argue that, although each participant shares several factors with the other two participants, there are significant differences in the metaparadigm concept of *nursing* between them. Using Fawcett's model to construct a metaparadigm of SF practice, I will conclude that the experience of nurses training in SFBT is dependent upon the paradigm of nursing from which they practice.

In Chapter Eleven I will address the quality issues relating to the project. I will argue that, in keeping with some of the qualitative literature, the issue of *validity* as it is understood in the natural (quantitative) sciences is redundant in terms of the human (qualitative) sciences, that the key issue in the human sciences is that of *believability*, and that that is a subjective judgement that can only be made by the informed reader. However, in order to help inform the reader, a number of quality measures are discussed and applied to the study. Finally, in Chapter Twelve, I present my concluding argument, and discuss areas of potential further research and the implications of my research for clinical and academic practice.

1.1 Chapter Overview

In this chapter I will argue that, despite the growing 'evidence base' of specific psychotherapeutic interventions for the treatment of psychological conditions, in any therapeutic encounter between a therapist and client, it is the therapist that activates change, as opposed to the therapeutic modality. Therefore, the object of any training experience in psychological interventions must be to change the practitioner in some way, in order that the practitioner may then engage with their clients more effectively. In light of that, I will

propose the research question, "What is the experience of nurses who have undertaken training in solution focused brief therapy?" I will make explicit the assumptions underpinning the question and discuss the principles that informed the development of the question.

1.2 Evidence Based Practice

My thesis will take as its point of departure the contemporary debate around *evidence-based practice* (EBP) in the psychotherapy and mental healthcare literature - in particular, the centrality of the randomised controlled trial as the evidence base of EBP. Norcross et al (2005) argue that, although psychological and psychiatric practice has always been based on the outcomes of scientific research, one of the key moments in the development of formal EBP was the publication of 'medicine's first randomized clinical trial' in 1948. In a similar vein, Scott and McSherry (2008) date the beginnings of EBP to the early 1970's and the pioneering work of Archie Cochrane. They note that,

"the revolutionary work of Cochrane advocated the use of randomised controlled trials (RCTs) to provide scientific support and evidence for effective medical interventions"

(p.1086)

While the validity of the RCT appears a relatively straight-forward concept in the world of physical healthcare; in the world of mental healthcare the role of the RCT in determining an evidence base for practice is far from accepted.

1.3 Randomised Controlled Trials and Mental Health

Although policy documents such as the Scottish Government's Matrix to Psychological Therapies (NHS Education for Scotland, 2011a) and good practice guidelines such as SIGN (Scottish Intercollegiate Guidelines Network, 2013) and NICE (National Institute for Health and Care Excellence, 2011) base their analysis on the 'gold-standard' of RCT based evidence, clinical and academic practitioners such as Barry Duncan and Scott Miller (Duncan and Miller, 2005; Duncan et al, 2007), Bruce Wampold (2001) and Michael Lambert (2013) reflect a counter-argument that successful therapeutic outcomes are based on a number of *common-factors* (such as the therapeutic alliance between therapist and client, and the therapist's personal allegiance to a specific therapeutic orientation) rather than a specific treatment effect related to a specific diagnosis. Most policy documents note (and appear to endorse) this argument; for example the Scottish Intercollegiate Guidelines Network (2013) note that,

"SIGN guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve".

(Notes for users)

Internationally, the Australian Psychological Society (2010) quotes the (Australian) National Health and Medical Research Council statement that,

“evidence is necessary but not sufficient in making recommendations for treatment. ... Effective evidence-based psychological practice requires more than a mechanistic adherence to well-researched intervention strategies. Psychological practice also relies on clinical expertise in applying empirically supported principles to develop a diagnostic formulation, form a therapeutic alliance, and collaboratively plan treatment within a client’s sociocultural context”

(p.3)

however, the recommendations made by these organisations are subsequently based on the evidence of RCT designed studies.

1.4 Clinical Outcome Research

However, it is not my intention to delve into this debate here; I cite it to demonstrate the non-paradigmatic status of the RCT in the psychotherapy literature. In the context of this debate, I would argue a specific point in relation to the education and training of practitioners in psychotherapeutic approaches. In broad terms, the RCT orientated literature usually seeks to demonstrate that *psychological therapy (a)* is more or less effective in reducing the symptoms of *disorder (b)* than the treatment received by a *control group (c)*. Inherent in this literature is the assumption that it is the psychological therapy *per se* that is the ‘active ingredient’ in treatment e.g. that CBT (*psychological therapy a*) is a more effective treatment for first episode depressive disorder (*disorder b*) than Rogerian counselling (*control group c*). However, my thesis is based on the assumption that the impact of any treatment approach is mediated by the practitioner delivering that

approach (at a very reductive level, a practitioner who is 'very good' at Rogerian counselling may be more effective than someone who is 'not very good' at CBT in treating first episode depression), and therefore it is the therapist who is the 'active ingredient' in the therapeutic encounter. In keeping with this, educating someone in a therapeutic approach is more than simply enabling them to deliver a set of techniques; education must in some way 'change' the practitioner in order that they can make a different therapeutic use of self in relation to clients. I would argue then that before we attempt to explore the impact of a therapeutic approach on clients, we should explore the impact of training in the therapeutic approach on therapists. Borrowing from Albert Ellis's A-B-C model of Rational Emotive Behavioural Therapy, in which Ellis argues that rather than an **A**ctivating event leading to emotional **C**onsequences for the client, the **A**ctivating event in fact leads clients to (rational and irrational) **B**eliefs about the event, which in turn lead to emotional **C**onsequences for the client (Ellis and Dryden, 2007); I would argue that, rather than **A**ny therapy impacting on a **C**lient [A-C], **A**ny therapy impacts on the therapist **B**etween the therapy and the **C**lient [A-B-C].

1.5 Research Question

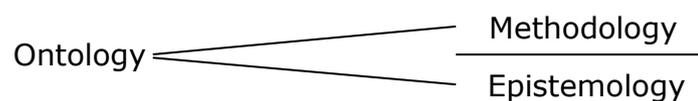
This then, is the basis of my research and the driver for the research question, "**What is the experience of nurses who have undertaken training in solution focused brief therapy?**" In forming this question, certain prejudicial assumptions are, of course, present. These are:

- Participants who found training in SFBT useful would be different in some way to participants who did not find it useful.

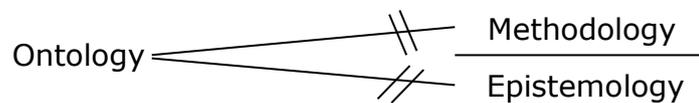
- Participants who found training in SFBT useful would be less satisfied with their previous mode of practice than participants who did not find it useful.
- Participants who found training in SFBT useful would be practising in a SFBT modality now.
- Participants who found training in SFBT useful would reflect a dissonance between their personal values and the dominant knowledge-base and practice of contemporary mental health nursing practice.
- Training in SFBT provided these participants with a suitable knowledge-base and practice within which to deliver ontologically congruent care.

1.6 Formulation

The formulation derived from these assumptions can be expressed as my belief that nurses will seek to practice in a manner that is congruent with both the contemporary body of nursing knowledge and their own personal values and beliefs. This could be expressed schematically as follows:



where *ontology* is the personal values and beliefs of the practitioner, *methodology* is the practice of nursing, and *epistemology* is the body of nursing knowledge underpinning practice. My assumption was that those nurses who found SFBT useful would reflect a dissonance between their ontology and the epistemology and / or methodology of contemporary mental health nursing practice. This could be expressed schematically as below:



Further to this, my assumption was that this dissonance would be dissolved through exposure to the practice of SFBT and / or the epistemological basis of SFBT. I therefore assumed that nurses who did not find SFBT training useful were either content with their current mode of practice, or did not find SFBT any more congruent with their personal values and beliefs than they had found previous modes of practice.

1.7 Principles informing Research Question

In addition to these assumptions, in forming the question to be answered here, three general principles informed my thinking. Firstly,

that it would be useful to design a research method that matched as closely as possible the solution focused (SF) method it was investigating. While some action research methodologies, such as interpretative phenomenological analysis (Smith, 1996; Reid et al, 2005) or cooperative inquiry (Heron, 1996) reflect to an extent some of the principles of SF thinking, as far as I am aware, SF has never been utilised as an explicit research methodology before and this would therefore be an original aspect of the research project. Second, and following from the first, the research was based on the premise that change is a constant factor of life. Reflecting Steve De Shazer and Insoo Kim Berg's (the founding co-authors of the SF approach) position that "change is continuous" (De Shazer et al, 1986; De Shazer and Dolan, 2007), this not only links the research method to the SF method but informs the question asked of participants in the study, "What has changed since you completed the SFBT training course?", in that it assumes that some change must have taken place although it does not assume that the change has been either positive or directly related to the course.

Finally, in keeping with Gregory Bateson's (1972) interpretive turn in social anthropology, in which Bateson argued that the receiving context of any observation patterns specific events for survival at the expense of others that do not fit with the observer's expectations, I chose to utilise as open an interview schedule as possible, whilst still focusing on the research question, in order to allow the participants to pattern the content of the data received. Each of these guiding principles will be discussed in greater detail later in my thesis; however, I include them here to make explicit the assumptions I had at the outset of the project (I would emphasise that these were merely informal assumptions, and not hypotheses which I was intending to prove or disprove), and the principles by which I hoped to reduce the impact of unconscious bias towards my prejudices. By making these

explicit, the reader is helped to decide to what extent I have overcome the 'thrall' of my prejudices (Gadamer, 1979).

Chapter 2: Solution Focused Brief Therapy

2.1 Chapter Overview

In this chapter the literature on SFBT will be reviewed. The search strategy employed to gather the literature will be made explicit prior to discussing the literature in detail. A brief overview of SFBT will be provided in order to orientate the reader to the general approach, the literature will then be reviewed in naturalistic stages; the general SFBT literature pre- and post-2000, the literature specifically relating to nursing, and finally, the literature relating to training outcomes with nurses. The latter stage will provide an analysis of four papers identified in the literature search as relating to training outcomes in nursing. The chapter will conclude with a critique of the literature relating to nursing as a whole.

2.2 Introduction

In any discussion of the impact of training nurses in SFBT it will, of course, be necessary to provide an overview of what SFBT is, and the literature relating to it. In this case, I carried out a review of the literature in order to identify what work had previously been undertaken in this field, and to what extent it could inform the research question. In doing this, I was guided by four inter-related questions relating to the literature. These questions were:

- what does a review of the SFBT literature tell us about the body of literature generally?
- what does it say about SFBT and nursing?

- what does it tell us about the outcomes of training people (specifically nurses) in SFBT?
- how does this inform the current research question?

I used these questions to help me focus the review, to help me decide what was relevant and what was more, or less, important in relation to the purpose the review was to serve. In doing this I was, arguably, already engaging in a hermeneutic process; the endeavour to uncover meaning from a body of texts in response to a specific question, 'what does the text tell us about ...', (as opposed to a more general question, 'what does the text say?') in an effort to fuse the horizon of the text with the horizon of my research question; in short, the literature review anticipates the wider hermeneutic process of the study to follow.

2.3 Search Strategy

The literature was searched using a number of databases including: AMED (Alternative Medicine), CINAHL, International Bibliography of the Social Sciences, ISI Web of Knowledge, MEDLINE, Pre-CINAHL, Sage Journals Online, and Zetoc. Search terms employed were "Solution Focused Therapy", "Solution-Focused Therapy", "Solution Focused Brief Therapy", "Solution-Focused Brief Therapy", "Solution-Focused Brief-Therapy", "Brief Solution Focused Therapy", "Brief Solution-Focused Therapy", "Solution Focused Approaches", "Solution-Focused Approaches", "Solution Focused Practice", "Solution-Focused Practice", "SFT" and "SFBT". Deliberately wide inclusion criteria were adopted; these were that papers must be published in English, have been published since 1980, and must refer directly to solution focused practice (as opposed to simply referring to it in passing). Exclusion criteria included book reviews, editorials, and published letters. In

addition to the above search strategy, the reference lists of included papers were searched for additional relevant material, and any papers identified in an ad-hoc manner, which met the inclusion criteria, were also included.

The literature search initially identified 744 papers, however many of these were duplicated within the various databases and search terms; a review of the initial returns therefore identified 375 individual papers, of which 305 met the criteria for inclusion. These papers were then filtered to identify those which specifically addressed nursing, those which specifically addressed the outcomes of training programmes, and which of those (if any) addressed both criteria. Twenty-one papers were identified that related directly to nursing, twenty-two papers related to training outcomes, and five related to both. However, one of these papers was a report on the Pilot Study of this project (Smith, 2010) and was therefore excluded.

2.4 Solution Focused Brief Therapy

SFBT is a psychotherapeutic model which aims to 'build solutions' rather than 'solve problems' (Popescu, 2005; Iveson, 2002). It differs from most other psychotherapies in this respect; rather than attempting to develop an in-depth understanding of the complexity, and history, of the presenting problem, SFBT looks to the future and focuses on the times when the problem is not experienced (exceptions). The therapist aims to help the client create rich descriptions of what their life will be like when the problem is gone, and to scale their progress towards achieving that state (Trepper et al, 2006). The approach was developed in Milwaukee, Wisconsin by a team of therapists, led by husband and wife team, Steve De Shazer

and Insoo Kim-Berg, who placed the approach in the tradition of noted brief therapists such as Milton Erickson, John Weakland and Mara Selvini-Palazzoli (De Shazer et al, 1986. p.208). Arguably, in setting out the theoretical background to their work in this way De Shazer and colleagues not only outline the “published history of brief therapy” as it relates to their own work, but seek to place their work firmly within that canon of brief therapy literature; in doing so, they not only provide a context for their work, but provide it with a lineage, or pedigree, as well. One of the more radical assumptions underpinning the approach was the assumption of client competence with which the therapy team approached their work; they assumed that clients already knew what to do to solve their problems, they just did not 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).

2.5 Literature Review

2.5.1 1980’s to 2000

Since its development in the 1980’s the use of SFBT has extended beyond family therapy and has been used in a range of diverse settings within and beyond the therapeutic milieu (Iveson, 2002, Trepper et al, 2006; Walsh, 2006). The early literature was largely descriptive, or theoretical, in nature (Sykes Wylie, 1990; Webster, 1990; Montgomery and Webster, 1994); scoping out and laying claim to the clinical territory the authors wished to colonise. Very little of the literature, however, was research based; De Shazer, while admitting that since its development, ‘research in to the approach ... has been minimal’ (De Shazer and Berg, 1997. p. 121) argued that the

research base of SFBT was one of 'naturalistic inquiry' based on the question, 'What do clients and therapists do together that is useful?', (p.122).

2.5.2 2000 – Present

However, in the last fifteen years there has been a marked growth in the research literature related to SFBT practice. In a review of the literature Gingerich and Eisengart (2000) identified fifteen controlled outcome studies of SFBT, although they found only five of these studies to meet 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 ten studies, described as 'moderately or poorly controlled', outcomes were 'consistent with a hypothesis of SFBT effectiveness' (p. 477).

Kim (2008) noted that in the eight 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 twenty-two 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. However, statistically significant differences were only demonstrated when SFBT was utilised in the treatment of 'internalised behaviour problems' such as depression, anxiety, or issues around self-worth. In treatment settings involving 'externalising behaviour problems' such as hyperactivity, aggression, or family and relationship problems, the effect, while positive, failed to demonstrate significance at the level of $p=0.05$. Kim notes that similar effect sizes

are reported for 'psychotherapy and other social work practice models' (p. 113), although he doesn't indicate what specific approaches he is referring to here.

Corcoran and Pillai (2009) reported on treatment outcomes resulting from experimental and quasi-experimental designs conducted between 1985 and 2006. They clearly state that,

"single-subject, single-group post-test only and singlegroup pre-test/post-test studies were excluded. Outcomes of studies necessarily varied, depending on the problem and population being researched, but data had to include client outcomes other than or in addition to client satisfaction."

(p.236)

Further information on search criteria, coding and data analysis is provided and, while less in-depth than Kim above, this provides sufficient detail to inform the reader. Although this review was conducted at roughly the same time as Kim's study above (both papers were accepted for publication in mid / late 2007), they share only six papers in common (60% of the published papers reviewed by both authors; Kim also reviewed unpublished dissertations, which Corcoran and Pillai did not); interestingly, while both authors cite their own previous work in this field, they appear unaware of each other's work and do not include this in their respective reviews. Of the ten studies reviewed, three had 'moderate effect sizes' (0.5 and above) and two had 'strong effect sizes' (0.8 and above), and like the previous reviews, this review concludes that further empirical research is required to establish the effectiveness of solution focused therapy.

Gingerich returns to the literature 13 years after his first review (with Eisengart) and identifies 43 studies for inclusion in a systematic review (Gingerich and Peterson, 2013). In this review, the authors are able to delineate the studies by treatment group and identify six separate groups; child academic and behaviour problems (14 studies), adult mental health (10 studies), marriage and family (6 studies), occupational rehabilitation (5 studies), health and ageing (5 studies) and crime and delinquency (4 studies). They recognise that some of these groupings, such as health and ageing, are simply heterogeneous groups of studies with no common research basis; however, they also note strengths in some of these particular groups. They praise the quality of the studies in the adult mental health group, particularly those of the Helsinki Psychotherapy Study group of Knekt, Lindfors and colleagues (Knekt and Lindfors, 2004; Knekt et al, 2008; Knekt et al, 2011), and conclude that there is strong evidence for the effectiveness of SFBT, particularly in the fields of adult mental health and occupational rehabilitation.

2.5.3 Critique

Importantly, all of these reviews and meta-analysis share a common problem, in that they are only able to review the so-called 'empirical' research; the experimental and quasi-experimental studies involving some form of randomisation. While Gingerich and Peterson (2013) record that their systematic review excluded 1391 of 1452 (96%) papers identified in their comprehensive literature search, neither Gingerich and Eisengart (2000) nor Kim (2008) report how many papers were initially identified prior to the application of inclusion and exclusion criteria in their reviews, and Corcoran and Pillai (2009) simply say that 'hundreds of papers' were rejected. They elaborate further,

“When treatment outcome research was involved, studies were often excluded because they were either single-subject designs or they were pre-test, post-test designs”.

(p.237)

However, in doing this, much useful research is lost, and (arguably worse) is deemed not to be a valid contribution to the knowledge base. Macdonald (2007) makes the distinction between efficacy studies and effectiveness studies, citing Seligman arguing that the latter are often of greater relevance to therapists. He goes on to state that

“Effectiveness data are available from 30 studies including more than 2200 cases with a success rate exceeding 60 per cent and using an average of 3-5 sessions of therapy time”.

(p.113)

However, it is left to the reader to establish for themselves whether these outcomes are significantly different from those achieved in other therapeutic approaches. This may well reflect the pioneering perspective of Steve De Shazer and Insoo Kim Berg who reflected

“We were interested in finding out what differences made a difference and we were not at all interested in proving anything to the outside world.”

(De Shazer and Kim Berg, 1997. p.121)

Nevertheless, it can be seen that there has been a growth in the research literature over the last ten to fifteen years; and this literature provides a modest evidence-base to suggest that SFBT is an effective intervention in a range of settings, particularly in the area of mental health and well-being.

2.6 The literature relating to nursing.

A review of the literature reveals an on-going body relating to SFBT and nursing practice. This 'SFBT and nursing' literature can be divided into two relatively distinct sections, reflecting the literature as a whole, as discussed above. The early work (Webster, 1990; Wilgosh et al, 1993, 1994; Montgomery and Webster, 1994; Iveson, 1995; Wilgosh and Hawkes, 1995; Hillyer, 1996; Sandeman, 1997) takes a largely descriptive focus and either analyses aspects of the approach, or advocates the use of solution focused practice in specific clinical areas. Hillyer (1996) offers an analysis of solution-oriented questions and argues that the concepts underlying these questions are consistent with nursing values

"which emphasize supporting clients' strengths, focusing on health rather than pathological condition, and respecting clients' abilities to arrive at answers that are meaningful to them."

(p. 8)

This developed the argument advanced by Webster in 1990, who had argued that while psychiatric / mental health nurses were mourning the loss of their previously intimate and long-term relationships with clients, SFBT offered a framework for practice that was congruent with

nursing, and feminist values. Among the latter values she cited the work of Kinney and Erickson, and Webster and Lipetz in suggesting that these include 'seeking to create an egalitarian interaction', 'valuing cooperation over competition', 'accepting personal experience as a valid source of information', and 'maintaining a balanced sense of responsibility for self and others' (p.17). This can be seen to reflect the earlier work of Carol Gilligan (1982) in developing an ethic of care derived from a feminine moral perspective. Montgomery and Webster develop this theme further (1994) when they argue that solution-oriented approaches provide a framework to promote a paradigm shift, from a cure-orientation to a care-orientation, in health care, and particularly in nursing. They argue that brief therapeutic approaches can enable nurses to re-engage with their clients; concluding that working within a caring paradigm nurses can

"respond to their [clients'] vulnerability rather than their pathology. Instead of diminishing our clients with the mystique of our own power and knowledge, we can give them a sense of their own power and help them rediscover their resources."

(p. 296)

As the theoretical and philosophical arguments became accepted, in some circles, solution focused practitioners began to publish papers arguing for the use of this approach in their specific field. Wilgosh et al (1994), in promoting the use of SFBT in mental health nursing, argue that SFBT builds on clients' strengths and resources, and utilises their potential to find their own solutions to problems. They also argue that the approach was congruent with the internal market approach to health care in operation at that time, in that it provided an open and accessible approach to counselling, and being a brief therapeutic approach it was able to meet clients' needs in a cost effective manner. They also describe, in a previous paper (Wilgosh et al, 1993), how to

conduct subsequent sessions after the first session. This is, perhaps, unusual, in that most authors focus on describing only the first session. This may be because it is felt that the first session introduces the reader to all the theoretical understanding, and practical skills they will require to carry out further sessions, or it may reflect the 'evangelical' nature of these early papers, and the assumption that once 'hooked' the interested reader would engage in further reading or training before beginning to utilise the approach in practice. In any event, Wilgosh et al note the scarcity of published material on subsequent sessions and pose the question,

"What is the next smallest step for the therapist and the client to take to maintain and build on the changes occurring?"

(1993, p. 31)

They then attempt to answer their question through the analysis of a single case study, utilising the acronym EARS (Elicit new information, Amplify the positive changes, Reinforce the significance of the change, Start again). Wilgosh and Hawkes (1995) later utilise a similar single case study approach to describe their approach to working with a violent client in a family context. Sandeman (1997) reiterates the message that SFBT enables clients to access their own resources in order to meet their needs, and advocates its use in community mental health nursing practice. She concludes that the approach provides community mental health nurses with a model of practice which is congruent with nursing values and, citing Hawkes and Marsh (1993), is in harmony with the nurse's role as a health promoter and provider of respectful, client-led therapy. Ferraz and Wellman (2008) concluded that

“SBFT principles and techniques are congruent with the philosophical underpinnings of contemporary mental health nursing, and can be safely incorporated into nursing practice. There are some indications from the literature that the application of such an approach may positively impact on nurses’ willingness to communicate with patients. There are also indications that the use of SBFT may help nurses develop a collaborative, goal-orientated approach to working with patients.”

(p.43)

It can be seen from this that these early papers represent the work of a small core of theorists and practitioners, working in various combinations, and building on their own previous work in order to establish a body of literature. However, while this may limit the objectivity of these early papers, similar observations could be made about the early literature base of many, if not most, other therapeutic approaches. The literature on cognitive behavioural therapy treatment for people with psychosis, for example, shows a similar cluster of interconnected authors (Vaughn and Leff, 1976; Leff et al, 1982; Haddock et al, 1993; TARRIER et al, 1988, 1998; Barrowclough et al, 2001; Sellwood et al, 2001) working together to develop an integrated evidence base for this approach.

2.7 Training outcomes with nurses.

In keeping with the SBFT literature as a whole, the nursing literature has become more research based since 2000. This may not be immediately apparent given the small numbers involved, however; 60% of papers relating to nursing, published since 2000, had a research basis compared with only 18% for the twenty years prior to 2000. Interestingly, over 80% (five out of six papers) of the post-

2000 papers relate to research into training outcomes as opposed to clinical outcomes. As stated previously, one of these five papers was Smith (2010) and that is not reviewed here; the remaining four papers are considered below.

2.7.1 Bowles et al.

Bowles et al (2001) evaluated the impact of solution focused communication training on nurses' communication skills. The training course being evaluated was delivered as a four day course over eight weeks and there were sixteen participants from a variety of nursing and health visiting backgrounds. The study incorporated qualitative and quantitative methods within a pre- and post-training design. Six 10-point Likert Scales were developed to measure themes related to how often, competent, confident, and willing participants were in talking to clients who were troubled. These were delivered pre-training and at a point six months post-training. In addition, a focus group was held at the six month post-training point. Only ten participants completed both pre- and post-test questionnaires, and five participated in the focus group; the authors readily acknowledge the potential for sample bias inherent in this situation, and recognise this as a criticism of the methodology employed.

Of the quantitative data, only two scales, 'willingness to talk to people who are troubled' and 'frequency with which the nurse speaks with people who are troubled', showed a significant difference (at the $P < 0.05$ level). The former showed a positive difference ($P = 0.047$), while the latter showed a negative difference ($P = 0.02$) in that nurses appeared to speak to people in distress less often following the training; the authors were unable to explain this outcome, and noted

that it appeared to contradict the other outcomes, particularly the 'willingness to talk to people who are troubled' scale. Of the qualitative data, the authors note two main themes emerging; these being participants experiences before their SFBT training, and their experiences after training. In terms of post training experiences they described three sub-themes; 'new tools which work', 'changes to interaction styles', and 'SFBT in other settings'. They conclude,

"There are indications that SFBT may be a useful approach to the training of communication skills, as it provides a structure and easily understood tool-kit that is harmonious with nursing values of empowerment, increased patient responsibility and participation in care"

(Bowles et al, 2001. p. 353)

There are, however, several methodological problems with this study. Primarily, the quantitative aspect of the study is based upon the use of participants' subjective response to Likert Scales. The authors argue that the use of these scales mirrored the scaling practices utilised within SFBT clinical practice, and "was considered to be a novel way to model the process of SFBT within the evaluation" (p. 350). However, the use of scaling questions within SFBT practice is seen to be explicitly subjective; writing on scaling, de Shazer noted that,

"It is important to remember that this sort of scale is a system not a yardstick. Scales are not measuring anything but rather they are designed to help both therapist and clients simply talk about complicated and vague topics."

(De Shazer, in online posting on BFTC website [now closed],

last accessed 22/11/07)

Therefore, the authors can be seen to be confounding a qualitative assessment tool with a quantitative analysis design. This may account, in part, for the contradictory outcomes generated; low sample size and a lack of established assessment tool reliability are additional factors. Furthermore, the focus group analysis clearly excludes those course participants who were not present, and only three of the five participants present are quoted (although some of them are quoted several times) in the qualitative findings section; this casts doubt on how representative the qualitative findings are of the group as a whole.

2.7.2 Stevenson et al.

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 hours) delivered as three cohorts over three months. Assessment measures included a pre- and post-course assessment of SFBT knowledge, assessment of the 'degree to which trainees demonstrated fidelity' to the SFBT model, an assessment of participants contribution to nursing notes to demonstrate active clinical use of SFBT in practice, assessment of clients' experience of SFBT interventions, and a brief evaluation questionnaire completed by the course trainees. Pre- and post-course assessments were carried out by eleven participants (48%), and there was a significant difference ($P < 0.01$) between time points. However, it may not be surprising that participants knew more about SFBT after completing a 20 hour course than they did before attending the course; arguably this relates more to the efficacy of the

teaching programme rather than anything directly connected to SFBT per se.

All participants demonstrated a fidelity to the model; however, only 47% were judged to have documented their SFBT practice well in nursing notes. Again, this latter point could be seen to reflect on the participants' nursing-note writing practice rather than their SFBT practice. Clients appeared to find the approach useful, with all clients reporting their experience either 'totally helpful' (50%) or 'helpful'. The authors identified four themes in clients' responses; these related to the nurse being able to focus on the clients' problem, ability to look forwards, making the client comfortable, and generating an 'uplifting mood'. In all themes the clients' experience had been positive. In addition, all of the trainees rated the course as 'very useful' or 'excellent' (a comparison between groups is not provided), and 83% stated that they would continue to utilise SFBT in their clinical work.

The authors draw no conclusions from the study beyond stating that the evidence suggests that both the nurses and their clients found the approach useful. Given the comments on research design above, and the lack of depth of the subjective assessment tools (the trainees' assessment tool comprised only two, Likert Scale, practice related questions), the authors would appear justified in both their conclusion and their decision not to generalise further.

2.7.3 Hosany et al.

Hosany et al (2007) report 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 in-patient units within a UK NHS mental health trust, undertook a two-day training course in solution focused therapy techniques. Participants were asked to complete a questionnaire prior to undertaking the training course, and then to repeat the process at two-weeks and three-months post training. The questionnaire took the form of basic biographical and existing knowledge details, followed by an unstated number (possibly eight) of visual-analogue scales asking participants to rate aspects of their clinical practice. The data from these scales was then analysed using the Wilcoxon signed ranks test, and compared at pre-training and three-month post-training stages. The authors report a significant positive shift in terms of participants reducing their focus on clients' problems ($P=0.001$), utilising a 'preferred future / miracle' question with clients ($P=0.002$), utilising '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.

A similar critique of this study can be made as to that of Bowles et al (2001) above; the authors have utilised qualitative data from analogue scales in a quantitative manner. The authors state that the areas where significant change was demonstrated are,

"key primary areas of SFT practice and the study has thus demonstrated that training this group of inpatient staff in the principles of SFT has significantly influenced their clinical practice".

(Hosany et al, 2007. p.693)

However, it could be argued that as the data was generated from a series of subjective rating scales, it would be more accurate to claim that the results demonstrate that the participants *believe* the training course has had an impact on their clinical practice, but this practice has not been assessed objectively. Given, though, that the rating scales identified 'key primary areas of SFT practice', and asked participants if they were utilising these techniques more since completing the two-day workshop, than they had prior to undertaking the training, it is, perhaps, not surprising that participants reported in the positive. Similar comments can be made here, in respect of research design, as to those made of Stevenson et al (2003) above.

2.7.4 Chambers et al.

More recently, Chambers et al (2013) discuss an evaluation of a four-day training course (one day per week for four weeks) combining Heron's six-category intervention analysis (days 1 and 2) with SFBT (days 3 and 4) delivered to a group of healthcare workers comprising five registered nurses, five healthcare assistants, two activity coordinators, one occupational therapist and one deputy ward manager (as eleven of the fourteen participants were involved in 'nursing', this paper has been included in the review of the literature relating to nursing). Their evaluation was in two parts; in the first part they carried out an end-of-training evaluation relating to the training process and participants' knowledge and skills. In relation to the latter aspect they found no significant difference between participants (self-reported) clinical behaviour before and after training. However, given that participants had received two-days training in both of the approaches, this is perhaps not surprising. The second part of the evaluation took place three months post-training and comprised two focus group sessions in which participants and their managers were asked to report on changes to their clinical practice. Both focus groups

appeared to have found the training useful and believed they were implementing what they had learned more fully with time; this was echoed by their managers.

“Both ward managers made reference to the increased confidence of staff and their ability to work better as a team resulting in a more therapeutic, respectful environment for both service users and colleagues.”

(Chambers et al, 2013. p.370)

This paper contains many of the methodological problems discussed previously. The evaluation of participants’ clinical behaviour pre and post training was conducted using the tool utilised by Hosany et al (2007) and is subject to the same criticism as above. Similarly, there is a tendency to report participants *perceived outcomes* as observed outcomes which, while a valid outcome in its own right, lends something of a distortion to the conclusions drawn. The inclusion of ward managers as external observers of participants’ behaviour is a useful, if not entirely independent, addition.

2.7.5 Critique

A brief review of the nursing literature related to SFBT highlights several points. Firstly, as pointed out above, it can be observed that the literature shifts from a descriptive phase into a research orientated phase at the end of the 1990’s. However, this body of literature is very small indeed, and suffers from a number of methodological flaws. The focus of this literature is on the outcome of training nurses in SFBT; however, this focus is directed to the impact of training on

nurse's clinical practice and interactions with clients. The literature is also based on the outcomes of training nurses in very short introductory training courses. It can be seen from this that none of the literature addresses the impact of longer training courses on nurses, nor does it address the impact of training on the way that nurses perceive themselves, their lives, or their profession. The methodology by which I hope to address some of these issues is presented in Chapter Three.

Chapter 3: Methodology

3.1 Chapter Overview

In this chapter a detailed description of the methodology utilised to conduct the research is provided. The chapter will describe the project in two stages: a descriptive phase (Stage I) and an exploratory stage (Stage II). In Stage I, I chose to utilise a specifically SF methodology; the rationale behind this and the process of formulating such a methodology is described. In Stage II, I felt it necessary to balance the innovative methodology employed in Stage I with a more widely recognised (but epistemologically congruent) methodology. The process of identifying such a methodology is described and, having identified Gadamer's hermeneutic phenomenology as an appropriate methodology, the background of this approach is critically discussed.

3.2 Stage I

Two factors guided my choice of methodology for the Stage I of this project. In the first instance I wanted to explore the *impact of training* on the nurses who had participated in SF training. This was, admittedly, a very broad and somewhat vague goal, but deliberately so. Had I focused on a more specific goal I would have been directing the lens of enquiry onto an area of my choosing; I would have been asking the participants to tell me what I wanted to hear about, rather than listening to what they wanted to tell me. The field of investigation was therefore the impact of training in SFBT on the participants, *as they had experienced it* and as they understood the

question; it followed from this that the methodology I adopted would lie within a qualitative framework.

Secondly, while undertaking the pilot project prior to commencing the MSc / PhD research proper, I had discussed with my mentor, Dr Bernice West, the potential to develop a research design based upon a SF methodology. Several authors (Bowles et al, 2001; Hosany et al, 2007) have attempted to utilise SF techniques in their work, but none have utilised a specific methodology based upon the assumptions and principles underpinning SF thinking. Some of these assumptions and principles would include valuing a 'not knowing' stance, and privileging the client's narrative, reflecting Bateson's (1972) interpretive turn in social anthropology.

Terni (2009) argues that SF practice can be seen to reflect an evolutionary algorithm in that it seeks to randomise behaviours, select the most adaptive new behaviour, and replicate that behaviour; there are clear links here with both the grounded theory approach (Glaser and Strauss, 1999) and (as I discovered) hermeneutic phenomenology. SF thinking also reflects these approaches in that it focuses on the presence of attributes (what's there, as opposed to what's not there), it focuses on 'what works', and it takes a specifically 'non-hypothesising' stance, co-constructing the perceived reality with the client / participant. Therefore, I believed the use of such a methodology would add to the originality of this research project.

3.2.1 Defining a SF methodology

However, describing such a SF methodology can be challenging. Traditionally, SF thinkers and practitioners have avoided explicitly defining what SF *is*, preferring to focus on what SF *does* (or *what happens* in a SF encounter). Hanton (2011) states that SF practitioners prefer to 'stay on the surface' of an encounter, thus avoiding becoming lost in their own theory-laden expertise. In this he is reflecting the stance taken by Steve De Shazer in which he argued that SF was based on a stance of pragmatic observation as opposed to one based upon a theoretically derived position.

"Like many or even most theories, such a theory tells us how things must be or should be rather than telling us about or describing how things are. ... It seems to me that only through learning to practice can therapists come to know SFBT."

(De Shazer and Dolan, 2007)

It can be seen, therefore, that most of the descriptions of SFBT and SF practice focus on process elements; the 'how to' aspects. While theory is discussed, most commonly in relation to Ludwig Wittgenstein (De Shazer and Dolan, 2007), it is the assumptions and interventions which dominate the literature (O'Connell and Palmer, 2003; Macdonald, 2007; Hawkes et al, 1998).

The definition of SF methodology used here is taken from the Association for the Quality Development of Solution Focused Coaching and Training (SFCT) and focuses on the basic position of the practitioner. These are:

- “Change is happening all the time – our role is to find useful change and amplify it.
- Resource orientation rather than a deficit orientation.
- A stance of:
 - having as few assumptions about the client as possible,
 - deeming clients to be the expert on their own lives and desires.
- A respectful, non-blaming and co-operative stance.
- An interactional view (in between [people] not ‘inside’ a person).
- Working towards our client’s goals from within our client’s frames of reference, while keeping our own (external) perspective.
- Treating each case as different and developing the process according to what the client says, rather than imposing a fit into a theoretical or conceptual framework: ‘the process emerges differently each time based on what the clients say/do/want’.”

(SFCT, 2013. pp129/130)

Looking at each of these positions will however enable some illumination of the SF methodology I utilised.

3.2.2 Change is happening all the time.

This position underpins the research question generally, and the opening question of the interview specifically. Since change is happening all the time, it can be expected that something has changed since the participant commenced the SFBT training course. Therefore the opening question, “What has changed since you commenced the Solution Focused Brief Therapy training course?” links change to the training experience, but does not stipulate the nature of the change; it is left open to the respondent to identify a specific change which they

link to having undertaken training. This change may be positive or negative, professional or personal, more or less obviously linked to the training experience; the point is that the 'change' is selected by the participant. Should the participant state that no change has taken place, this then becomes a significant event (given that change happens all the time), and this 'non-change' would become the focus of conversation. Thus, by linking change with the training experience, the discussion of change is implicitly also a discussion of the training experience. (In writing this, it appears to me that the process of *intentionality* was already present, albeit unknowingly, in my methodology).

3.2.3 Resource orientation.

The methodology that I utilised in Stage I assumed that the participant I was interviewing was doing their best to provide me with the most appropriate response to my question. Where the response did not appear 'satisfactory' (for want of a better term), it was incumbent upon me to assume that the participant was doing their best to answer the question and the problem of understanding was mine, not theirs. I therefore could not simply dismiss something I did not understand on the basis that the participant had not understood the question; rather I had to assume greater competence on the part of the respondent than on my part, and ask how I could make sense of their response. Although this rarely happened, it was an important aspect of my methodology (although this rarely happened in Stage I; it was of major importance in Stage II).

3.2.4 Having as few assumptions about the participant as possible.

Although I knew all of the participants from their time as students on the course, it was important to me that I made as few assumptions about them as individuals as possible. I took a deliberate stance of not assuming that they had found their training experience useful, or equally that they had found it not-useful. Other 'non-assumptions' included whether they were now using SFBT in their practice, whether I would find what they told me useful, or any recollections I had about their performance while on the training course. Specific assumptions that I did make about the participant were that they were competent people and practitioners, and that they were being as honest with me as they were able; these, however, were general assumptions made about all participants as opposed to specific assumptions made about any individual participant.

3.2.5 Deeming participants to be the expert on their own lives and desires.

This is similar, in some ways, to the position of taking a resource orientation to the participant. The object here was to ascertain the participants' experience of having undertaken a training course in SFBT, that is, their *self-perceived experience*. The participant was taken to be the expert in their life and, as such, they could accurately describe what they had experienced. Equally, it was assumed that the participant was the expert in what they wanted to get from the experience – their desires. Although in many cases these are unarticulated desires, it is a core assumption of SF practice that the participant 'knows what they want' - they just may not know that they know it. Therefore, the participants have an unspoken benchmark against which to judge their experience. There was therefore no intention to 'test' their account by seeking verification from colleagues or records, or any other external source. The raw data being generated was from the participants' expert account.

3.2.6 A respectful, non-blaming and co-operative stance.

The key aspect here is one of co-operation. The narrative accounts that were generated from the interviews in Stage I would be co-constructed by the respondent and me, my role was to ask initial questions and then seek clarity and detail from the answer the participant presented; there was therefore no attempt to bring a positivistic objectivity to the encounter, each conversation was a unique event between two people. Within that conversation, I was assuming that the participant was being the 'best participant' they knew how to be, and I likewise, was doing my best to enable them to 'tell the story' they wished to tell.

3.2.7 An interactional view.

This position reinforces that made above; that the focus of enquiry was on the data that emerged from an interactional experience, as opposed to any thoughts that were 'inside' the participant and were to be mined, uncontaminated by that process, by me. Of note here, both Steve De Shazer and Hans Georg Gadamer argue that understanding comes through dialogue. De Shazer, and his colleague Gale Miller, quote Ludwig Flett in saying,

"He is a poor observer who does not notice that a stimulating conversation between two persons soon creates a condition in which each utters thoughts he would not have been able to produce by himself or in different company".

(Miller and De Shazer, 1998. p.363)

while the principle is at the heart of Gadamer's fusion of horizons. He argues that

"To reach an understanding with one's partner in a dialogue is not merely a matter of total self-expression and the successful assertion of one's own point of view, but a transformation into a communion, in which we do not remain what we were".

(Gadamer, 1979. p.341)

3.2.8 Working towards the participant's goals, while keeping our own perspective.

The key aspect here is the keeping of my own (external) perspective. It could be suggested that some of the positions adopted above could result in me blindly accepting the participant's account of their experience; arguably leading to a narrative of what the participant (and I) *wished* had happened, divorced from what might have been suggested from a more observational stance. In short, it could be suggested that the participant and I were enclosed in a 'creative bubble' devoid of contact with the external world. However, this position helps to counter the risk of that drift, in that it makes explicit the need for me to retain a link to my own external perspective. While this may sound like a contradiction in terms, in essence what it means is that I not only remember that I do not know what the participant knows, but that I also remember that I do know what *I* know; this then becomes the basis for requests for clarification on my part.

Where there is something the participant tells me about a specific situation that is at odds with my understanding of that situation either generally or specifically, I can take a position of 'being confused' ("I don't understand; I thought ...") and seek clarification from the participant; this then becomes a SF *challenge* in a sense, challenging from a co-constructive, rather than adversarial, perspective.

3.2.9 Treating each case as different.

This final position informed the overall process of Stage I in that, as far as possible, each interview was conducted in isolation of all the others. Specifically, there was no attempt on my part to formally synthesise data as I progressed through interviews and to use that synthesis as the basis for informing future interviews. Had I done so I would have been privileging earlier interviews to pattern responses which I would then have sought confirmation of from later interviews; this would clearly have contravened my central principle of not patterning any responses for survival at the outset of the interview process. Therefore, each interview was conducted as a unique event, using the same process, but allowing "the process to emerge differently each time based on what the [participants] say/do/want" (SFCT, 2013. p130.)

An analysis of the data generated in Stage I can be seen in Chapter Five.

3.3 Stage II

Following transfer from MSc to PhD research I came to realise that, in order to help demonstrate the validity of the methodology I had developed for use in Stage I, a recognised methodological framework should be adopted in the second Stage of the research. According to Miles and Huberman (1994), it "is good medicine ... for researchers to make their preferences clear" in selecting a methodology (p4) and they go on to outline a number of approaches to qualitative research design. Given the importance of narratives, to me, in how we construct and shape our world, this initially appeared an ideal approach. However, it quickly became clear to me that while I could use the transcript data I had as 'narrative data', it did not readily present itself as a *narrative*, that is emplotted diachronic descriptions of events in a temporally bounded story giving meaning to the data as a unified whole. In other words, the distinction made by Polkinghorne (1995) between the paradigmatic analysis of narrative data and the analysis of emplotted narratives, in which the former seeks to identify and categorise themes, while the latter aims to organise the data into a coherent story, holds true here, with my *narrative data* reflecting the former. In short, in order to reconstruct the raw data into emplotted, diachronic, temporally bounded stories I would have to change them so much I could not be confident of their veracity at the end of that process.

Having discounted a purely narrative methodology then, I was led by Miles and Huberman (1994) to consider an ethnographic approach. This would be in keeping with Bateson's epistemological basis in Social Anthropology which, as mentioned previously, had partly informed the design thus far. According to Tesch (1990) ethnography is an appropriate methodology for research into "the characteristics of language as culture" (p72). Given that SFBT uses language as a very

specific tool, this then appeared to have some links. However, not all the links were clear, and some element of dissatisfaction remained. Given that the purpose of my study was to develop an understanding of the experience of those nurses who had undertaken training in SFBT, a further branch of Tesch's overview of research types showed promise. The "comprehension of the meaning of text/action" appeared to mirror the aims of my study and, according to Tesch, is best achieved through a phenomenology design or a hermeneutic design depending on whether one seeks to discern themes in the 'text/action' or interpret the meaning of the 'text/action' respectively. This, then, seemed an appropriate methodology.

3.3.1 Phenomenology

Initially exploring phenomenology as an approach, the work of Martin Heidegger (1962) and Edmund Husserl (2012) appeared to shine a light on the current project, particularly in relation to the concept of intentionality. It appeared to me that the object of my investigation was 'the experience of training in SFBT' and that this would be pursued through the subjective experiences of my respondents. However, a number of problems became apparent as I considered this approach.

Firstly, I could foresee a potential conflict between the notion of an essence at the heart of the experience of training in SFBT and the SF premise of continual change. It seemed to me that there existed a conflict between an objective essence and non-permanence; it may be that the essential nature of Heidegger's Being lies at a deeper level of Being than training in SFBT, that training is simply another subjective aspect of Being. However, speculation like this seemed unlikely to advance my exploration of the subject at hand. Secondly,

phenomenology is, of itself, descriptive, it seeks to describe 'what' occurs; 'that which shows itself' (Heidegger, 1962; Crotty, 1998). While this was helpful in relation to the first part of my study, the 'what happens', it clearly would not engage with the second part of my study; 'why does it happen?' (In writing this chapter, I have come to realise that there were significant aspects of a phenomenological approach inherent in the methodology of Stage I of my study).

Finally, I had doubts about the feasibility of bracketing (Husserl, 2012) in either part of the study, but particularly in the second part. In order to develop an understanding of why events had occurred, it seemed to me impossible that I could remain outside, or separate, from the discussion. Although this at first appeared to echo the SF notion of 'non-hypothesising', Steve De Shazer often advised therapists to 'forget' what they 'knew' about a client before they met the client and base their therapy on what the client presented them with (he often quoted Doyle's Sherlock Holmes, "It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts" [De Shazer and Dolan, 2007]). De Shazer's position relates only to what one knows (or, more correctly, has been told) about the client ahead of observation, while still allowing the therapist to maintain a stance of curiosity. In other words, the therapist maintains a presence in the dialogue, bracketing only some specific information, and even here the information may re-surface as the basis of the therapist's 'curiosity'. Clearly, although in some ways similar, bracketing is not congruent with the SF design I was seeking, and did not fit with my concept of interpretation.

3.3.2 Hermeneutics

Through this path of discovery then, I was led to the hermeneutic of Hans-Georg Gadamer (1979). Gadamer argues that hermeneutics is not a method to be applied by a researcher to data in order to construct meaning; rather it is the exploration of the process that is undertaken by the researcher in constructing meaning from the data. The role of hermeneutics is

“not to develop a procedure of understanding, but to clarify the conditions in which understanding takes place. But these conditions do not amount to a “procedure” or method which the interpreter must of himself bring to bear on the text; rather, they must be given”.

(p.263)

The process to be explored, the ‘conditions in which understanding takes place’, is largely determined by the prejudices and fore-sights of the researcher. Understanding thus becomes a creative process in which the conditions of creation are as important (if not more so) than the creation itself. However, while Gadamer moves beyond mere method in the understanding of events, he continues to advocate for the essential quality of science in questioning and research. He concludes ‘Truth and Method’ with the assertion that the involvement of the questioner’s own being in answering the question asked does not mark the limitations of the scientific process, only that of method. Here then is an approach which, while remaining ‘text-focused’ (De Shazer, 1994), allows the interpreter to utilise the fore-sights he or she brings to the endeavour in a restrained and scientific manner. The hermeneutic circle and fusion of horizons inherent in Gadamer’s work resonates strongly with the iterative co-construction of solutions inherent in the SF approach; here I feel I have found an appropriate methodology, approached through an iterative process of question and

answer, relevant to the research question and reflecting the SF approach I had aimed to achieve.

3.4 Hans-Georg Gadamer

Gadamer can be seen as synthesising two distinct philosophical traditions. Essentially a hermeneutist, Gadamer was steeped in the tradition of Schleiermacher and Dilthey (Gadamer, 1979). Traditional hermeneutics had taken the form of interpreting Biblical, and other theological texts, in order to better understand the meaning the original author intended to convey. Gadamer cites the early work of Spinoza in this regard, in which Spinoza discusses the inherent problem of understanding phenomena which lie beyond the experience of 'natural reason' (he refers to 'stories of miracles and revelations');

"all the important issues can be understood [Spinoza argued], if only we understand the mind of the author 'historically', ie overcome our prejudices and think of nothing other than what the author would have had in mind."

(Gadamer, 1979. p159)

3.4.1 Schleiermacher

However, Schleiermacher expanded the scope of hermeneutic endeavour beyond Biblical interpretation towards a universal hermeneutic in which the hermeneutic gaze could be directed towards understanding any text or discourse (Warnke, 1987). Where Spinoza would have seen the need for hermeneutic interpretation only where

the author's meaning was obscure, Schleiermacher took the position that *misunderstanding* was the norm and the universal application of hermeneutic principles was necessary in order to engage with the original meaning of a text.

"For from now on we are no longer concerned with the difficulties and failures of understanding as occasional, but as integral elements, which have to be excluded. Thus Schleiermacher even defines hermeneutics as 'the art of avoiding misunderstandings'."

(Gadamer, 1979. p163)

3.4.2 Dilthey

Gadamer argues that Schleiermacher shifts the hermeneutic problem from simply understanding texts themselves to understanding the author in their individuality through psychological (as well as grammatical) interpretation (1979, p164). Dilthey developed this new direction further, exploring the potential for a methodology of interpretive rules and regulations allowing an objective understanding of wider social interactions, including social interactions and practices, social norms and values (Warnke, 1987). Dilthey brought to hermeneutics a fully developed historical perspective, in which the tradition of romantic hermeneutics was expanded "into a historical method, indeed into an epistemology for the human sciences" (Gadamer, 1979. p174). This *method* that Dilthey conceived of can be seen as a nineteenth-century attempt to apply the rigour of the natural sciences to the human sciences, one in which the goal of hermeneutics

“points towards the construction of precise methods to capture the meaning as it is in itself, stripping away any ‘modern’ assumptions or prejudices, just as natural scientific experiment tries to exclude extraneous effects.”

(Outwaite, 1985. p.24)

This, however, is the point where Gadamer departs from the traditional hermeneutic enterprise. For Gadamer the focus of understanding is less on the original meaning intended by the author at some point in history, and more on the meaning a text has for us today. Gadamer’s aim is more than simply a cerebral understanding of the data being examined; it extends to a genuine engagement with the data.

“The whole value of the hermeneutic experience ... seemed to consist in the fact that here we are not simply ordering knowledge in compartments, but that what we encounter in a tradition says something to us. Understanding, then, does not consist in a technical virtuosity of ‘understanding’ everything written. Rather, it is a genuine experience, ie an encounter with something that asserts itself as truth.”

(Gadamer, 1979. p445)

3.4.3 Brentano

In engaging with both the present experience of, and the historicity of, the text Gadamer clearly draws upon his experience as a student of phenomenology, and particularly, as a student of Martin Heidegger. Heidegger had, in turn, been influenced by the writings of Husserl and Brentano before him. Brentano addressed the same question which

Aristotle had grappled with and which had underpinned philosophical thinking since, 'what is being' (Krell, 1993. p4). He saw himself as an empirical scientist, expressing the view that experience alone was his teacher, and it was he who first utilised the term 'phenomenology' to describe the process of descriptive psychology he taught at the University of Vienna (Crotty, 1996). Of particular importance, Brentano originated the concept of intentionality; the relationship between a psychic entity and the physical entity it relates to, between the subjective and objective experience.

"Every mental phenomenon includes something as an object within itself, although they do not all do so in the same way. In presentation something is presented, in judgement something is affirmed or denied, in love loved, in hate hated, in desire desired and so on."

(Brentano, 1995. p68)

Brentano links this 'mental in-existence' (by which he means 'existence in' [Crotty, 1996. p50]) to Aristotle and the Neoplatonists; for example he cites St Thomas Aquinas' teaching, "when the Scriptures speak of an indwelling of the Holy Ghost, St. Thomas explains it as an intentional indwelling through love" (p67) to support his argument. Crotty (1996) argues that to address the intentional object in our experience we must transcend our subjectivity and become one with what is known. He goes on to state (p41) that for Husserl, this intentionality was the 'general theme' and 'threshold' of phenomenology.

3.4.4 Husserl

Central for Husserl was the attempt to control the subjective in what was essentially a subjective endeavour; to introduce an 'objective' scientific method to the phenomenological process. This he attempted to do through the '*epoche*', or bracketing; an attempt to transcend self and engage with the thing itself.

"Through the process of bracketing, [Husserl] seeks to move from naïve understanding of the object to the object itself, understood intuitively, as it presents to consciousness in an original and direct fashion ... It leads us back to more than just our experience in its immediacy and its primordially. It leads, Husserl claims, to pure consciousness and pure Ego."

(Crotty, 1996. pp. 59/60)

Thus, Husserl sought to do more than simply recognise the preconceived ideas we might have about an object; he sought to transcend our 'worldly-ego', the accumulation of self, and attain a state of un-tarnished transcendental Ego through which to intend to the object of investigation. While, for me, there is a Zen-like (apparent) simplicity in Husserl's method, Gadamer (2000) argued that the process was, at best, misguided.

"The reflective self falls into an endless process of iteration, since the reflection can always reflect again upon the reflecting self. Thus it follows from the structure of reflection itself that it is trapped in an empty iteration. This is Husserl's concept of a transcendental subjectivity: that it involves this unending, empty iteration. Heidegger's advance consists in the fact that he himself ... invalidated the concept of self-consciousness and its role as the support for Transcendental Idealism."

(Gadamer, 2000. p.280)

3.4.5 Heidegger

Heidegger returned to Brentano's central question of being, but addressed it not as an external problem to be understood from outside of being, but from the position of 'the human being who posed the question' (Krell, 1993). For Heidegger the central question was one of Being-in-the-world (*Dasein*), in which all understanding becomes self-understanding, and the issue of objectivity becomes marginalised. Warnke (1987) argues that while Heidegger began,

"with the question of 'being' of a specifically human self-understanding, his answer is that this being is time. All understanding is related to self-understanding and self-understanding is thrown projection; this means that it begins and ends outside the subject – in a past it did not create and a future over which it has no control."

(p.40)

For Gadamer, Heidegger revolutionised phenomenology (and hermeneutics) when he placed the question of being within the 'horizon of time'.

"Thus the structure of temporality appeared as the ontological determining factor of subjectivity. But it was more than that. Heidegger's thesis was that being itself is time. This burst asunder the whole subjectivism of modern philosophy."

(Gadamer, 1979. pp.227/228)

However, as Vessy (undated paper) points out, Gadamer was always quick to praise Heidegger and to suggest that there was a proximity between his own work and that of his former teacher. However, while Heidegger may have rendered arguments of objectivity / subjectivity redundant for Gadamer, for other authors the impact of Heidegger's work in this area is less clear. Crotty (1996) argues that Heidegger implicitly advanced his own reduction through the 'return to the things themselves'; by addressing only Being as revealed through Dasein he was in effect bracketing the 'free-floating constructions', 'accidental findings' and 'pseudo-questions' of day-to-day experiences. He goes on to quote Heidegger himself, in arguing that Heidegger's phenomenology was a philosophy of method rather than a philosophy of content,

"The expression 'phenomenology' signifies primarily a methodological conception. This expression does not characterise the what of the objects of philosophical research as subject-matter, but rather the how of that research."

(Crotty, 1996. p.81)

Arguably then, it was Gadamer himself who completed the process of removing the Transcendental from the process of uncovering meaning. By recognising that the historicity of Dilthey's hermeneutics extends across the temporal sphere to include the present and the future, Gadamer not only fuses hermeneutics with phenomenology in a *hermeneutic phenomenology*, but lays to rest (for some) the illusion of objectivity that had beset both disciplines. More than this, he demonstrates that any endeavour that attempts to replace engagement with method ignores the fact that understanding comes through a dialogue, guided by a "discipline of questioning and

research" (Gadamer, 1979. p447), in which the one is directly engaged with 'the other'.

3.4.6 Critique

However, it could be asked, "what is the real difference between the 'method' of Husserl (and for that matter, Dilthey, and indeed Heidegger as well), and the 'discipline' of Gadamer?" In a sense, is Gadamer splitting hairs when he rejects method for discipline? While the question may be justified, it is to miss the point though. For Gadamer, hermeneutics was about more than a method for ascertaining an objective truth about a text, a piece of art or an experience. It is an engagement with something, out of which an understanding is created; the creative step being the difference between *knowing* what an author has written and *understanding* what the author has written in a contemporary sense. In relation to his long-standing debate with Emilio Betti, Gadamer summarised his position thus;

"Obviously I have not succeeded in convincing Betti that a philosophical theory of hermeneutics is not a methodology – right or wrong ('dangerous'), as the case may be. It may be misleading when Bollnow calls understanding an 'essential creative act' – although Betti does not hesitate to describe as such the interpretation of law, which is a creative elaboration."

(1979. p.466)

The clear implication of the statement is that for Gadamer too, understanding is an essential creative act. Gadamer does not lose

sight of the fact that the truth of that understanding must be apparent, but argues that in the human sciences this involves more than the mere empirical knowing of the natural sciences. Warnke (1987) summarises this clearly:

“On Gadamer’s view an adequate account of the principle of understanding requires a break, then, with both the natural sciences and with the history of modern hermeneutics itself. If this hermeneutics is characterized by the turn from the truth-content of a claim to the intentions behind it and thus from the validity to the question of method, the turn must be reversed.”

(p.41)

3.4.7 Conclusion

Thus, the methodology adopted for this study utilises a mixed method approach within a qualitative paradigm. The study, overall, comprises two Stages; Stage I employs a qualitative SF methodology to explore *what* was the experience of participants with regard to training in SFBT, Stage II uses a qualitative Gadamerian hermeneutic methodology in order to better understand *why* specific participants may have had the experience they reported. The application of a mixed method approach, arguably, reflects a pragmatic perspective (Patton, 1990) congruent with the ontological perspective of both SF thinking and Gadamer’s heremeneutic. That there are similarities between the methodologies implemented in Stage I and Stage II of the study is, of course, not accidental. The methodology used in Stage I was designed to reflect the assumptions and principles of SF thinking, while the methodology used in Stage II was specifically chosen to be compatible with that of Stage I. This similarity could, though, be seen

to diminish the impact of (or even the claim to) a mixed method approach. Traditionally, mixed methods research has been seen to combine qualitative and quantitative methodologies to generate a more robust study than either approach would provide alone (Cresswell, 2009); however, if we accept Rolfe's (2006) argument that a unified qualitative research paradigm does not exist, we can be allowed to envisage a mixed methods approach in which *qualitative methodologies* are combined to generate a more robust study than either approach would provide alone. Issues surrounding the design of both parts of the study, and the ethical considerations undertaken, are discussed in Chapter Four.

Chapter 4: Design

4.1 Chapter Overview

In this chapter a discussion is undertaken of the research design developed and utilised in Stages I and II respectively. Given, as discussed in Chapter Three, that Stage I of the research involved the development of a SF methodology, a detailed description is provided of the process by which the research design for Stage I was developed. The key questions addressed to participants in both Stage I and Stage II of the research, and the rationale behind them, are fully discussed. Finally, a discussion of the ethical implications of the study design is discussed.

4.2 Introduction

The aim of the study (i.e. Stage I and Stage II) was to answer the research question **“What is the experience of nurses who have undertaken training in solution focused therapy?”**; however, three specific objectives were also identified, and the design of the study sought to address these objectives too. The objectives are:

- To generate an understanding of the impact of the course on participants.
- To develop an understanding of the process of learning and change experienced by the participants.

- To construct a theoretical explanation of this process in relation to the relevant literature.

4.3 Objectives

A pilot study carried out in 2008 (Appendix 1) reported on the experience of the first cohort of students to complete the Solution Focused Brief Therapy course at Robert Gordon University (Smith, 2010). Having already participated in the pilot study this cohort of students was not included in the main research project being considered here. Although the emphasis of the pilot study was on the impact of training on trainees, the focus of my interest quickly changed from '*what was the impact?*' to '*why was that the impact?*' This, then, became the first objective of the current project; to generate an understanding, if possible, of why the course impacted on participants as it did.

From the pilot study it was apparent that the course had had a profound effect on the practice and wider lives of some of the participants, while for others the impact was limited. In an effort to understand what specific factors might have influenced this difference, the second outcome emerged: to develop an understanding of the process of learning and change experienced by the participants. Given the suggestion in the literature that SFBT is congruent with nursing values and that nurses find it easy to integrate SFBT into their practice, I hoped that an understanding of the process of learning and change experienced by the participants would enable this transition to be explained at a theoretical level. This then became the third objective of the study.

4.4 Stage I

The study population was a convenience sample made up of former students who had completed the Solution Focused Brief Therapy course at Robert Gordon University. This sample had several advantages in that they had all undertaken the same training course, the content of which was known to me; they were all members of the Aberdeen Solution Focused Therapy Forum (although they were not all based in or around Aberdeen), which provided a legitimate channel of communication through which to request their participation; and they all knew me, better enabling them to judge whether they wished to enter into a research relationship with me. Moreover, as the study design and methodology was qualitative in nature, there would be no attempt to generate generalisations based on the data.

4.4.1 Initial intentions

I had initially intended to address the research question by interviewing as many former students as possible, and considering these interviews as narrative accounts of the former students experience. I had planned to treat these accounts as raw data and to analyse this data using a paradigmatic analysis approach (Polkinghorne, 1995) in order to identify and categorise emerging themes. From this 'group narrative' several 'individual narratives' would be selected to represent typical and atypical experiences, and these would be subject to narrative analysis techniques (Polkinghorne, 1995) in order to organise the data into an emplotted 'story' with inherent unity and meaning; this would be Stage II of the study.

It was my intention to interview each participant using a semi-structured interview technique for a maximum of 45 minutes. Interviews would follow a solution focused perspective in attempting to co-construct with interviewees a narrative response to the question, "*What has changed since you commenced this solution focused therapy training course?*" In utilising this solution focused perspective, the design of the study was intended to mirror the post-modern epistemology of SFBT, and apply it in a research setting.

This approach is consistent with, and develops, the approach taken by Bowles et al (2001) in 'modelling' the SFBT approach in their research design, whilst maintaining a rigorous qualitative methodology. Participants would be asked to respond to the above question and I would encourage them to elaborate on their responses. A thematic guide and interview schedule is contained in Appendix 2. Interviews would be audio taped and transcribed, the resulting narratives analysed to identify similar instances in the data, which would be identified and grouped according to emerging categorical and conceptual definitions.

4.4.2 Subsequent additions

However, a significant change to this intention occurred in the summer of 2009 when I recognised that a cohort of students would be commencing the course in September of that year. This would allow me the opportunity to have students record their *lived* experience of training in SFBT, in addition to the *recalled* experience which other former students would provide. A number of ethical problems were however evident; unlike the earlier method, this would involve the active participation of students while they were still students on the

course. Clearly, this raised issues of confidentiality, respondent bias, and coercion of participants to take part in the research.

A range of steps were taken, including involving a research assistant to conduct a focus group, the strict separation of my researcher role and my course leader role, and measures to ensure the confidentiality of data (specifically from me) until students had completed the course. To this end, a former student who had participated in the Pilot Study and would not therefore be participating in the main study, was approached and asked to act as a research assistant and conduct a focus group on my behalf. Having agreed to this, he obtained informed consent from students who wished to participate in the study, and compiled a list of these students contact details along with their completed consent forms. These details were then kept in secure storage by the senior course administrator in order that I would not know which of the current cohort of students had agreed or declined to participate. I had no further research role with these students until they had completed the course and their details were then passed to me.

Ethical approval was re-sought from the School Ethics Review Panel for the changed design, and this was granted. Students in this cohort were asked to keep a personal learning diary noting their experience as they progressed through the course. They were also invited to take part in an on-line blog where they could share their experiences, and to participate in a focus group session, facilitated at the end of the taught practice period, by the research assistant. It was thus expected that this additional data would add to the richness of these participants' narratives. In the event, few students actually kept the learning diary, and the on-line blog contributed no data of value. However, the focus group did contribute material, which was treated as a group narrative, subjected to the paradigmatic analysis described

above, and produced some useful data, which is discussed in Chapter Five.

4.4.3 Final design

Having contacted 75 potential participants by email, through a professional support group in the summer of 2010, 31 former students who had completed the course responded and, due to actual availability of respondents to be interviewed, 20 interviews took place at various locations across Scotland. As a minimum, 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 assessment. An alternative definition of completion was that the participant had withdrawn from or failed to successfully complete the course (a small number of participants did not submit the final essay and, therefore, did not complete the course). All 20 interviews followed a semi-structured format, allowing me to respond to participants responses and develop emerging themes as appropriate. The initial question, "What has changed since you commenced the course?" allowed participants to choose how best to reply in relation to their experience. To help expand on the initial question, several *anchor questions* were developed; these sought to break down the temporal boundaries of the emerging narrative into convenient sections. The anchor questions used were:

- How would you describe your practice before you commenced the course?
- What were your expectations when you applied for the course?

- On a scale of '0' to '10', where '10' is 'all your expectations were fully met and you got what you wanted from the course', and '0' is 'you got nothing from the course, it was a complete waste of time', to what extent were your expectations met?
- What would have made your experience '1' point higher?
- How would you describe your practice since you have completed the course?

4.4.4 Anchor questions (Stage I)

The first of these questions was designed to explore what the participant had been doing before they commenced the training course; whether the participant had already been working in a SF manner, were they satisfied with their style of practice and what approaches (if any) had informed their work. The second question follows from this and seeks to ascertain what it was the participant hoped to gain from the training; were they looking for 'something else' and, if so, what? These two questions were designed to illuminate my prejudicial assumption that participants who found training in SFBT useful would be less satisfied with their previous mode of practice than participants who did not find it useful.

The third question is a technique all of the participants would be familiar with, as scaling is a central aspect of SFBT, as a means of discussing their position on a defined construct. As such, it was designed to not only help the participant focus their thinking on the value of the training experience to them, but helped to set up the next question. The next question (What would have made your experience '1' point higher?), while also a familiar question to the participants, was designed to allow participants to discuss what they 'did not like

about the course' but wouldn't otherwise mention. This seemed to me an important point in that, the participants and I have a previous (generally) warm relationship and, the potential for respondent bias is clear. This question enabled participants to be critical of the course while voicing a positive message; for example, 'more theory' implicitly means there was not enough theory in the course, 'less practice time' means there was too much time spent in practice.

The final question was designed to explore what the participant was actually doing now in order to ascertain a) if they had found the course useful, did that translate into continuing practice, b) if they had said that they were still using SFBT in practice, could they give examples of this (or were they just being nice to their former lecturer), and c) to illuminate my prejudicial assumption that participants who found training in SFBT useful would be practising in a SFBT modality now.

Participants responses were then discussed in a manner in which my curiosity to know more about their experience drove the discussion. In this respect it can be seen that the content of the interview was co-constructed by the interviewee and me jointly. Interviews were audio taped and transcribed, transcripts were then analysed using an adaptation of Colaizzi's (1978) seven-step formulated meaning model, whereby significant statements were parsed into discrete statements of formulated meaning, and were then identified using a recursive analysis, as contributing to emerging themes (see Chapter Five). Based on the analysis of individual narratives generated in Stage I, both a 'group narrative' and a typology of experience were created and these were used to identify participants for inclusion in Stage II.

4.5 Stage II

As referred to earlier, it was my intention in Stage II to take a small number of typical and atypical narratives and analyse them through a narrative analysis framework (Polkinghorne, 1995). However, very few of the participants provided what could be considered as clear narrative accounts of their experience and (as I discussed in the Chapter Three) I was of the opinion that to reconstruct their accounts into a temporally bounded, unified narrative would involve such a degree of reorganisation on my part that the resulting accounts could no longer be considered as believable representations of the participants own experience. Furthermore, I came to believe that some form of external (in the sense of being external to my project), recognised methodology, which was congruent with the methodology and design of Stage I, would strengthen the design of Stage II. In light of this, and having decided to utilise a Gadamerian hermeneutic phenomenology methodology, the design of Stage II required to be altered.

Having created a typology of experience, two participants who reported a 'satisfactory experience' and two participants who reported a 'less than satisfactory' experience were selected for further interviews (all participants had agreed to be contacted again, if required, at the end of the first interview). In the event, only one of the latter group could be contacted, and therefore there were three participants in Stage II. These three participants were asked to participate in a semi-formal interview in which anchor questions were based around aspects of the group narrative generated in Stage I, and served as the basis for a co-constructive conversation similar in interactive style to that previously carried out. Building on Stage I, which had sought to understand 'what' had happened to the

participants, these questions sought to understand 'why' it might have happened. The questions addressed issues around:

- Why the participant became a nurse (or other discipline, if not a nurse)
- What further training they had undertaken, and why
- Their experience of working in a CBT approach
- Why they chose to train in SFBT (what they were looking for)
- How satisfied they were with their practice experience before and after SFBT training
- What influence they believe their practice environment played in the above
- An exploration of the congruence of the ontology, methodology and epistemology of their clinical practice before and after SFBT training
- Their future professional goals

4.5.1 Anchor questions (Stage II)

The first two questions seek to explore what it is that the participants are trying to achieve through their chosen profession. This reflects an awareness generated in Stage I that different participants see their role in different ways, and that thinking in terms of the 'role of the nurse / therapist' as a single unified (and understood) concept is erroneous. Therefore, these questions explore why the participant entered their profession and what they have done since then in terms of becoming 'more like' what they want to be (there is a hidden assumption here that further training would be undertaken because it would progress the participant towards the goal of what they wanted to become). The third question reflects a specific outcome from Stage

I, that almost all participants had some sort of contact with Cognitive Behavioural Therapy (with various degrees of satisfaction), and seeks to explore that further. The next question (Why they chose to train in SFBT [what they were looking for]) builds on the first two questions to an extent (in that it seeks some form of congruence between what they 'wanted to become' and why they applied to train in SFBT), and also replicates the question asked in Stage I; thereby requiring a richer, more detailed response.

The following question seeks to elaborate on this question further, while the next question again (What influence they believe their practice environment played on their satisfaction) seeks to explore an emerging premise from the typology generated in Stage I. The penultimate question addresses my prejudicial assumptions that participants who found training in SFBT useful would reflect a dissonance between their personal values and the dominant knowledge-base and practice of contemporary mental health nursing practice and that training in SFBT provided these participants with a suitable knowledge-base and practice within which to deliver ontologically congruent care.

The final question is designed to close the circle initiated by the first two questions by exploring what the participant still has to do to become the practitioner they wanted to be. Interviews were, again, digitally recorded, and transcripts generated from each recording. Transcripts were then treated as textual data and engaged with in an iterative process in order to develop a hermeneutic understanding of the inherent meaning. Texts were read repeatedly, interviews and texts were reflected upon, meanings were generated and examined in relation to the text (and often subsequently abandoned), and I subsequently became 'immersed' in the texts at a level beyond *thinking*. (I am reminded here of Coleridge's poem 'The Aeolian Harp'

[Raine, 1957. p30] in which he describes his relationship with the Incomprehensible as; "For never guiltless may I speak of him, The Incomprehensible! save when with awe I praise him, and with Faith that inly *feels*". In this instance the 'faith' being the faith that the sensual understanding of 'feeling' is of a more immediate nature than the logical understanding of 'thinking' and, as such, is an appropriate source of understanding to be logically examined). In short, what I understand as the hermeneutic circle. This process continued until such time as I felt able to claim a (greater or lesser) merging of my 'world' with that of the text and, as such, achieve a fusion of horizons. My interpretations of these texts then serve as the basis for a wider discussion around *why* these participants had these experiences of training in SFBT and what understanding can be taken from that. Analysis of the narrative texts generated in Part I of the study will be considered in Chapter Five.

4.6 Ethics

Prior to commencing the study, in accordance with Robert Gordon University Research Ethics Policy (Robert Gordon University, 2009), approval was sought from the School of Nursing and Midwifery's Ethics Review Panel. The principal ethical issue was one of practitioner research relationships; the relationship between participants, as former students of the SFBT training course, and my role as researcher and also as Course Leader for the training course. The advantages and pitfalls of conducting practitioner research are well recorded. Lunt and Fouché (2010) synthesise the major arguments, suggesting that the advantages include being better able to develop collaborative relationships with participants, being able to underpin research questions and aims with contextual knowledge, and the ability of the practitioner/researcher to value practice skills in the context of research activity. They suggest that the pitfalls of practitioner

research include a potential reduction in the ability of practitioners to be self-critical, being able to manage competing accountabilities, and role blurring in terms of balancing the day-to-day role with that of a researcher. McLeod (2003) defines these ethical problems as arising from the competing demands of the therapist/researcher to meet the needs of the client, and of the researcher to make a meaningful contribution to the knowledge and understanding in the subject area. Clearly, in the case of my research, there can be seen to be the potential for conflict between my role as a solution focused therapist and a teacher of solution focused therapy on the one hand, and as a researcher into the impact of training in solution focused therapy on the other. As a therapist/teacher I clearly believe solution focused therapy to be an important therapeutic approach, and would like to believe the course I run is effective in teaching practitioners how to practice in a solution focused way; as a researcher, however, my credibility lies in the honesty with which I can relate to others in a rigorously ethical and valid way. McCormack (2009), however, argues that practitioner research is no different to any other research approach, in that it requires the same methods of rigorous and systematic enquiry, clearly linking methodology, method and analysis. He goes on to argue though that, given the risks of the practitioner researcher being closely involved with participants and the multiple contexts in which the research takes place, reflexivity is of heightened importance in practitioner research. Issues of reflexivity are discussed further in Chapter Eleven.

An additional question existed around whether ethical approval would be required from the National Research Ethics Service (NRES) as the research involved NHS personnel. A request for clarification was submitted prior to commencing the study and NRES advised that, as the project did not involve patients or patient data, NRES approval was not required.

Within the September 2009 cohort additional arrangements were made whereby potential participants were informed of the study by letter prior to commencing the course. This letter clearly stated that there was no obligation on any student to participate in the study, and I would not be aware of who was taking part in the study and who was not. Details of the study, a list of Frequently Asked Questions, and a copy of the brief research proposal were made available to potential participants via the University's website. As discussed in Section 4.4.2 above, a Research Assistant was also used to provide face-to-face information on, and gather all data in relation to the Focus Group materials.

Finally, as a nurse researcher and practitioner, I have to consider research ethics in the context of ethical nursing practice. Sellman (2011) argues that ethical nursing practice is underpinned by the principles of honesty, justice and courage aligned with the dispositions of trustworthiness and open-mindedness (p.107). These last two factors, in particular, are emphasised by this research design. Open-mindedness in the sense that I am not patterning any specific information for retrieval but, rather, asking the participants in the study to share with me what they think is relevant to my broad-based, open-ended question; trustworthiness in the sense (to paraphrase Potter [2002]) that I can be 'counted on to take care of those things entrusted to me' by participants; their stories, trust and good-will. This trust, I would argue, is embedded in the relationships the participants and I developed, relationships in which not only I endowed the participants with these qualities (or my faith in their presence), but in which they also endowed me with these qualities. Danchev and Ross (2014) argue that,

"People in the caring professions want to make a difference to people and want to be involved relationally in order to achieve this. The

relationship between the researcher and the participant is just as significant, so it is unsurprising that a whole field of study has evolved around the term 'relational ethics'".

(p.47)

They propose that, within the context of relational ethics, the ethically sound researcher must give attention to four major considerations: "the relationship with the research context; the relationship with the research subject; building a research relationship; and maintaining a research relationship" (p.48). I would contend that the research design utilised here, combining as it does elements of both SF thinking and hermeneutic design, addresses all four of these relational aspects in an ethically sound manner.

An analysis of the texts generated in Stage I of the study is provided in Chapter Five, and detailed analyses of the texts generated in Stage II of the study are presented in Chapters Seven, Eight and Nine.

Chapter 5: Analysis of Texts (Stage I)

5.1 Chapter Overview

In this chapter an analysis of the narrative texts generated at various points in Stage I is provided. The text generated by the focus group interview will be explored, as will the data generated from personal diaries and online blogs, and specific examples will be discussed. The texts from all twenty interviews are then considered and fully explored in the context of a narrative analysis, a thematic analysis and the construction of a typology of participants' experience.

5.2 Stage I: What happened?

As stated in Chapter Four; 75 potential participants were contacted and invited to participate in the study, 31 responded (41%) and 20 interviews (27%) took place over the summer of 2010. Additionally, and prior to the 20 individual interviews taking place, a group interview (the Focus Group, [n]=7) was conducted by my Research Assistant on the 15th October 2009.

5.2.1 Focus Group Interview

The Focus Group interview was digitally recorded and, once it was made available to me (see previous Chapter for my discussion of the design protocols adopted around the 2009 cohort of participants),

transcribed. Transcripts were thematically analysed using an adaptation of Colaizzi's (1978) seven-step formulated meaning model, whereby significant statements were parsed into discrete statements of articulated meaning, and were then identified using a recursive analysis, as contributing to emerging themes. These discrete statements were structured as poetic stanzas as I believed this would convey the intense, detailed meaning of the participants narrative in an accessible format (Riessman, 1993); this aspect of the study is discussed in greater detail in Chapter Eleven reflecting on 'Red Herrings'.

Three themes emerged from the focus group; these were *Client Empowerment, Success, and Experimenting*. The first of these themes reflects the participants' belief that working in SFBT has enabled them to empower their clients to take control of their own conditions and lives. This reflects a changed perspective for the participants, and one that is in keeping with the solution focused model.

"It's so much more helpful than, 'what's your problem, let me solve your problem';
'I can't solve your problem',
'I don't want to hear it.'

We're very poor at giving
patients control, we pay
lip service to empowerment
and collaboration."

(Participant A in Focus Group Interview)

"I feel I'm not having
to pull rabbits out of hats,
and, I never could,
but somehow I thought I should."

(Participant B in Focus Group Interview)

"The thing I like about the Miracle Question is that it's out of our hands. It's nothing to do with us; it's the power of the person. It's not us waving a wand, it's not us doing the miracle. It's 'something that just happens', and they experience it."

(Participant C in Focus Group Interview)

In all three of these accounts there is a sense of empowering clients to truly take control of their own situations. The accounts of Participant A and B clearly relate a sense of being unable to personally 'solve' clients' problems despite an expectation (at least on their part) that this is what they should be doing. Participant A highlights this when she states that "We're very poor at giving patients control, we pay lip service to empowerment and collaboration", suggesting that, while we pay 'lip service' to patient centred care, much of our work with clients is controlled by, if not us (as nurses), then mental health services in some shape or form. This comment was echoed by some of the participants in the Stage I interviews, none more explicitly than Norman,

"A lot of people say they work in a strength-based way ... or a solution focused way ... but, when you look at it ... in a way, you think 'well, how?' "

(Norman)

Here, the participants in the focus group, despite being only four weeks into their training, appear to be recognising the extent to which they are now becoming aware of client empowerment in their practice, but also the extent to which they had previously been blind to it in their previous practice. A related theme of *Success* also emerged from the focus group discussion. Here participants reflected on their perception that the new techniques and approaches they were learning appeared to work in practice, as illustrated below:

"I've found it seems to be
incredibly helpful; clients
seem to be incredibly helped.
Clients seem to find it really empowering.

When they walk in the room
and everything about them,
their body language and their poise
says, 'I am absolutely overwhelmed'.

And by the end of the session
there's just a difference,
the way they hold themselves,
their voice. It's just a significant shift".

(Participant B in Focus Group Interview)

"You expect the Miracle Question to be a big deal,
but actually, the times I've used it,
in the standard format,
folk are just straight into it".

(Participant D in Focus Group Interview)

"I've noticed that when you ask things
like the Miracle Question,
or, 'how would that help?',
people come up with things;
that, they themselves,
surprise themselves with.

In terms of 'what is it that I really want?'
and then are able to discover that actually,
this thing that I really want
can no way happen in this situation.

And they start to make connections".

(Participant E in Focus Group Interview)

In these accounts participants express their experience of success in the four weeks they have been utilising SF techniques in their practice. A number of issues appeared to contribute to this theme; one was a sense of how much more helpful this approach was than the participant had been used to (or at least, expected it to be), Participant B talks about client's being *incredibly* helped and finding her new style of interactions *incredibly* helpful, suggesting a more than marginal shift. Another issue underpinning the *Success* theme is the link with *Client Empowerment*; Participant E relates this in terms of clients being able to reflect on their behaviours in relation to their expressed goals. Questions like, 'how would that help', enable clients to look at their anticipated behaviour in the context of a strategic goal and query whether the behaviour is likely to result in the desired goal; the emphasis in Participant E's account is that the clients 'start to make connections', which is presumably a different outcome from that which she experienced previously (otherwise it would not have been noteworthy).

The final issue underpinning the participants success narratives is that of overcoming their own 'fears' at practising in a new way. Participant D highlights this; inherent in her account is the feeling of anxiety around using the newly learned Miracle Question, and her surprise that clients are more accepting of this new (to her) question than she had anticipated. The Miracle Question is a specific technique employed in

most first session SFBT interviews, and included as standard in the SFBT course, in which the practitioner asks the following question of the client, making deliberate use of pauses to allow the client to imagine their response. "*Suppose...tonight....after this session....when you've done all the things you would expect to do today....you go to bed.....and you fall asleep. While you're asleep....a miracle happens. The miracle is that the problems we have been speaking about are solved! But...you don't know a miracle has happened because you are asleep. When you wake up tomorrow morning, what will be some of the first things that you will notice that will be different that will tell you that the miracle has happened?*" The intention behind the question is to open up a strategic dialogue with the client around the client's *positive future scenario* (i.e. what they would like their life to be like; life without the problem), generating as much detail as possible in order to then ascertain how close the client thinks they are to achieving that state of being (the assumption being clients are already much closer to their positive future scenario than they realise).

This aspect of the *Success* theme links with the final theme to emerge, that of *Experimenting*. While both *Client Empowerment* and *Success* echoed similar themes from the Pilot Study, *Experimenting* was unique to the Focus Group, perhaps reflecting the fact that the group were only beginning to practice in an SF way and, unlike the more experienced stage of practice enjoyed by participants in both the Pilot Study and Stage I interviews, were, indeed, experimenting with their practice, as reflected here:

"Even after one day,
it was successful enough
to say, 'Actually, this might be
useful in a difficult situation with
this particular client'".

(Participant F in Focus Group Interview)

"I haven't managed to find a phrase yet,
to find a phrase that works.
I tried a magic wand, and her response
to that was, 'well I haven't got one,
so it doesn't really matter'; that kind of
finished the conversation.

I wasn't experienced enough
to, kind of, say, 'well, if you did though,
what would you do then?'
Which is what I should have done,
but I didn't".

(Participant G in Focus Group Interview)

Participant F reflects on her awareness that even after only one day she was considering ways in which she could introduce SF practice into her clinical work; in this she echoes the observations reported in the nursing SF literature (Bowles et al, 2001; Stevenson et al, 2003; Hosany et al, 2007), that nurses can incorporate SF practice into their work after a very short period of training. Participant G reports a more tentative approach in which she is working towards an ownership of her practice, finding a way to internalise the Miracle Question in order to ask the question in a genuine and congruent manner (to borrow from Carl Rogers; it can be seen though that SF practice is congruent with, and builds upon, the Core Conditions of the Rogerian approach). Of interest, having met with a perceived failure in practice, she has developed a response that may enable the client to take that step towards a positive future scenario, and she recognises the growth that she has experienced through that encounter. So, a sense of *Success* is extracted from a narrative of *Experimentation* that did not work; arguably, this can be seen as a response to the participant's (silent) question, 'What else could you do to help the client answer the

question?' in itself, a typical SF intervention. The full thematic analysis of the Focus Group Interview can be seen in Appendix 3.

5.2.2 Further 2009 Data

Although the Focus Group Interview provided some interesting data, it could be argued that it is not unexpected for a group of students to express their enthusiasm over the acquisition of new knowledge and skills in the early stages of a course, particularly where that group of students have volunteered to participate. In fact, the specific activities carried out with the 2009 cohort of the SFBT training course added little to the overall understanding of Stage I. All course participants in 2009 were given a 'Research Diary' and invited to keep a log of their thoughts and experience, and to return it (if they wished) at the end of the course. In the event, only two participants returned their diary; both diaries containing four entries. Both diaries revealed something of the experimentation of practice and thinking that might be expected of practitioners trying to integrate a new form of therapy into their practice, as demonstrated here:

"If I gave you a magic wand, what would you wish for?
Nothing, everything in my life is fine.
A discussion today with an alcohol dependent patient in crisis. I'm not sure if SFBT is effective in times of crisis as the patient is not always willing to look at solutions at these times".

(Extract from Diary 1)

"When we sat down, I said, 'You've passed an important milestone since we last spoke. How did it

go?' (1st anniversary of the death). Claire (pseudonym) explained that it had been better than she had expected. When she told me what she had done, it was easy to compliment her on knowing what to do. My old way would have been to focus on the pain of the anniversary.

Her ambivalent feelings toward her mother gradually came out more and more, along with guilt for the things she hadn't done, the ways she hadn't been (spending more time, doing jigsaws together....) I asked coping questions – 'so when you think about those things, how do you manage to keep going?' My old way would have been to focus on her ambivalence and her right to be her".

(Extract from Diary 2)

In the first extract it can be seen that the participant is experimenting with her role and some of the contextual factors which might have an impact on the therapeutic process. In the second extract, the participant appears to be having some success in changing from a problem-focus to a solution-focus; however, the experimental nature of this can be seen from a later entry,

"The next client was someone I've seen quite a few times. I have never adopted a SF approach with her. She talked, mostly about her sons and others, never about herself, and I really struggled to stay focused. It had been a long day, but I just didn't seem to be able to get engaged. Finally, I said, 'We've got 10 minutes left, and for those 10 minutes, I want you to talk only about yourself!' She just about managed it. I didn't feel the session was of any benefit to her."

(Extract from Diary 2)

While the author of Diary 2 is able to utilise SF practice in some settings, she is unable to do so in other contexts. Both of these diary accounts possibly illustrate two things; one is that both participants were continuing to practice and experiment several months after the taught course was completed, the second is that their thoughts may provide a slightly more textured account of the supposed ease with which nurses incorporate SF into their practice. On the basis of this evidence, it could be argued that, while these nurses achieved an enthusiastic understanding of the core concepts of SF practice very quickly, they were still undergoing a complex assimilation process some six-months after that initial exposure. This clearly adds to the conclusions drawn by Bowles et al (2001), Stevenson et al (2003) and Hosany et al (2007), in their respective papers on the ease with which nurses engage in SF practice. This sentiment was also expressed by a participant in the Focus Group who suggested that, while SF appeared a rather formulaic approach on first impression, a deeper understanding revealed how complex and interactive the approach could be, as indicated below:

“There’s just so much depth
to something which at the surface,
you look at and you think
it’s just so formulaic”.

(Participant H in Focus Group Interview)

In addition to the diaries, participants were invited to participate in an anonymous online blog. I had hoped that participants would be able to co-construct something of a group discussion, or group narrative, by responding to each other’s thoughts and experience, and reflecting on their own. However, there were only six posts to the blog, over half of which related to how to post on the blog and the remaining two being a brief discussion between two participants on the difficulties one

participant was experiencing, with the other recommending a DVD she had borrowed from the University library. All-in-all, while I hope the dialogue was helpful to the participants, the blog did not contribute anything to the data collection in Stage I.

As stated previously, twenty interviews with former students who had completed the course previously were conducted over the summer of 2010. Interviews were audiotaped, transcribed and were then analysed in three ways. As described in the following sections, data were analysed using a narrative analysis technique in which the description of the participants' experience were emplotted into a temporally bounded story. Data was then analysed using the adaptation of Colaizzi's (1978) seven-step formulated meaning model as described above in relation to the Focus Group data. Finally, the resulting data was used to construct a typology of experience, in which two key domains were identified; these were then used to inform the selection of participants in Stage II of the research.

5.3 Narrative analysis of data.

Transcripts, transcribed by me, of all twenty interviews were analysed using a narrative analysis technique (Polkinghorne, 1995) in which the data contained in the narrative accounts was reorganised into a sequential narrative beginning before the participant began the SF training course and ending by looking ahead to the participant's future plans. Prior to undertaking the interviews I had anticipated that participants would respond to my key questions with a temporally bound narrative with a beginning, a middle and an end. Although the key question (what has changed since you commenced the SFBT training course?) is rooted in the present moment, its focus is

historical and supplementary questions were utilised to encourage participants to construct a chronological narrative around the change they were describing. In the event, very few participants produced coherent temporally sequential stories; the majority responded with loosely connected short stories richly textured with non-verbal gestures, shared understandings and leaps to related thoughts and ideas – never to return to the unfinished original. The following extract is typical:

“I think it just struck a chord ... with what I was doing, I really ... I suppose, and what could I do differently. Cause I’m always one for, it doesn’t matter what you go on, you get something out of it, even if the something is very, very small, you get something out of it ... but I got an awful lot more out of it than I anticipated.”

(Agnes)

In fact, there were only four examples of chronologically structured stories in the un-restructured data, an example is shown below.

“It’s fair to say that I have used it, and I have used it a few times; the full session. I actually used it, and used it very successfully. I must say it was a bit of an experiment because I was just ... sometimes in primary care, y’know, sometimes you’re just faced with ... and it was a son, well it was a teenager, who arrived with his mum and dad and they all wanted to come into the session, and I was sat there with a family in front of me; had never dealt with a family before, had obviously had a husband or spouse before, but never had a family, and I thought ‘Wow, what am I gonna do with this?’ and I thought, ‘Right, I’m going to do a SFT session here’, and I did. And it worked so well.”

(Geraldine)

This is, however, not uncommon; Fraser (2004) notes that one of the key tasks in interpreting narrative data is “to disaggregate long chunks of talk into specific stories, or segments of narratives” (p189), and Polkinghorne (1995) states that the task of narrative analysis is to compose the elements of an historical description of an event into a story, noting that the data does not usually present itself in a storied form at the outset.

The restructured narratives were composed around several key temporal ‘milestones’. These milestones served as markers on the chronological journey each participant had undertaken, and were given titles representative of the stage in the journey. The key milestones are discussed below.

5.3.1 Pre-training practice.

Participants were, generally, quite reluctant to discuss this period in detail, often comparing it to their current practice and then going on to describe their current practice in greater detail.

“I would always go in and say, ‘How’s things?’, now I go in and I say, ‘What’s been good?’; that’s another thing I tend to use, and actually now people just come in and tell me what’s gone well.”

(Agnes)

When they did describe their previous practice, most participants did not recall utilising a specific therapeutic model, rather their practice was based on intuitive problem solving, and advice giving. Many participants had had some exposure to Cognitive Behavioural Therapy (CBT) oriented approaches; however, these tended to be brief workshops, often connected to Professor Chris Williams, SPIRIT (Structured Psychosocial Interventions In Teams) model of CBT inspired self-help booklets.

"I guess it was a mix, we did tend to use the ... in terms of the CBT ... I guess the Chris Williams stuff ... we used a lot of that material; we did come from that perspective. However ... I would also introduce in a sort of eclectic, and in a felt sense, often with the person, whether they would engage with the mindfulness idea."

(Norman)

Many participants also found their role at this time very stressful in that they felt an obligation to 'solve' people's (often very complex) problems for them.

5.3.2 Expectations.

Surprisingly, few participants had any clear expectation of what they would get from training in SFBT. The majority of participants were looking for 'a new tool' they could utilise in clinical practice; this would suggest an eclectic outlook to practice, in which they saw themselves as 'skilled helpers' adopting the best therapeutic tool for the job. I would suggest this is in keeping with the pre-training experience described above. Many of the participants had heard something of

SFBT before, but a significant proportion also described simply liking the sound of the name; focusing on solutions seemed to appeal to them. This may suggest an ontological bias, in at least some of the participants, towards a 'positive outlook'.

"I liked the idea of it ... I liked the idea of looking at solutions and liked the idea of "I need to up my skills as a practitioner"; I came from working as a CPN, and I'm going to say this – I hope this is confidential – but y'know, it was a bit like 'Groundhog Day'!"

(Jerry)

5.3.3 Course experience.

Generally, participants' experience of the course was very positive. Despite not having a clear expectation of what they would gain from the course, most participants expressed the belief that their expectations had been, at least, met and in many cases exceeded. There appeared to be three main features in regard to the level of satisfaction participants experienced in their training; these were the degree to which they acquired a 'new tool' for practice, the degree to which they got to *use* that new tool in practice, and the degree to which the training provided an epistemological framework that better matched their individual ontological outlook than their current framework did. Those who were least satisfied with their experience typically reported being less able to use the new tool in practice than they had anticipated and appeared more satisfied with their existing epistemology than their colleagues; understandably, while they reported enjoying the training experience, they had gained little from it, as shown here:

“Probably about a 7. From the course itself, I think I did get most of what I expected; but actual, my whole expectations of using it at work, at the moment, aren’t what I expected.”

(Judy)

Participants were asked to scale their experience on a scale from ‘0’ to ‘10’, where ‘0’ represented a situation where they had gained nothing from the training experience and ‘10’ represented a situation where the training experience had met all their expectations; this is a common SF technique with which all the participants were familiar. Participants responses to the scaling question ranged from ‘7’ to ‘12’, with a modal response of ‘10’; it can be seen from this that the typical experience was one of a high level of satisfaction with the training experience, as indicated below:

“I would say 12. It met, and exceeded, what I thought I would get from it. I not only use it with client groups, but I can use it to manipulate the establishment in all sorts of positive ways. It also makes it easier in my personal life to deal with all sorts of difficulties; it’s good to have an approach that you can use as a ‘lifestyle choice’ ... it gives you choices, it’s something that you do to yourself.”

(Perry)

5.3.4 Enhancement.

Two key areas were identified by those who suggested things that would have enhanced their experience; these were related to further

SF theory, and a greater opportunity to practice. In the first instance one participant spoke of wanting to spend more time formally studying SF theory to help her develop her understanding of the subject, and had this to say:

"I think, for me, maybe having more case studies, of ... maybe, a whole case and what happened in each session. More discussion about "if this person came to you with this particular problem, what would you start off with, and what would you do?", and that type of thing."

(Ellen)

another participant spoke of a desire to know more about the evidence base supporting SF practice in order to counter dismissive comments from colleagues, as illustrated here:

"I think some clinicians look at solution focused therapy and they think of it as ... avoiding the issue. I get a sense of that from certain colleagues ... or have had ... it's like, 'that's all very well and good, focusing on solutions, but actually ... the bit that's creating the problem in the first place isn't getting addressed and ... no matter how much you try and expand that ... the exceptions, you're still going to have it being squeezed by the problem', and so, I guess at some level, clinically dismissive of it, at that level ... and I guess I think ... solution focused therapy, if it's to counter that charge, needs a good clinical evidence base."

(Norman)

Participants also spoke of desiring a greater opportunity to practice their newfound skills and to share their interest with colleagues. The

latter comments link to the observation above; that participants who were unable to utilise SFBT in practice were less satisfied with the overall experience (it follows that the experience would have been enhanced if they had been able to practice more).

5.3.5 Post-training practice.

Participants spoke readily about their current practice, the majority of whom described their current mode of working as 'solution focused'. Many stated that they were more satisfied with their 'new' model of practice and found that they were now more inclined to empower clients to change rather than trying to change things for them. This was variously described as 'empowering clients', 'giving clients responsibility for change' and 'clients taking more responsibility for their lives'; however, in all cases it appeared to involve the participant trusting the client's choices and the client's agenda over that of the service.

"I'm listening to what the client's solutions are ... their exceptions ... the things you don't hear if you don't ask the question. And often the solution is so far out of the left field ... I'd never think of it. It's just about stepping back and saying, "They will find it". Just give them space and a bit of encouragement."

(Karen)

It was thus, a source of surprise and satisfaction for many that clients appeared to 'get better', in that they were quickly able to recover sufficient equilibrium in their lives that they were able to resume living without access to services, or to reduce the amount of support they

required. Practitioners also spoke of using the approach in an eclectic fashion, using the 'SF tool' often, but not exclusively, as seemed to them appropriate to the client's needs. It was interesting to note how many participants became almost apologetic in tone when discussing this aspect of their practice, as though they were 'letting the side down' in some way by not sticking rigidly to the SFBT model as taught.

"Obviously, I don't do the whole ... the whole ... the Miracle Question I only do ... I tend to do if I'm struggling ... with somebody. I tend to have it as ... straightforward. But the exceptions I always use, I find that, y'know, really helpful. Which was something that seemed so simple, but it's not something I did before, but you get so much from it, just getting them to see, "Oh yeah, okay. I was doing that last week", y'know. So I find that hugely helpful and use it all the time. Scaling I use all the time as well; I find that extremely helpful ... and just looking at the positive."

(Agnes)

I found this interesting for two reasons; (i) it suggested to me that these participants had come to 'own the approach' for themselves and were able to integrate the techniques into their mode of practice, in other words they had passed beyond technical competence and approached expert practitioner status (Benner, 1984), (ii) it demonstrated that even when these participants were embarrassed, or uncomfortable, with what they were telling me, they were still able to trust me with that information, in other words they were willing to tell me things they thought I did not want to hear. While many participants spoke of the success of working with clients in a SF way, a small number told a different story, of being unable to incorporate SF approaches into their practice. These participants spoke of the difficulties of introducing SF practice into a ward, or team,

environment, where SF was not the dominant mode of practice, as exemplified here:

“There’s only been one person I’ve managed to use the full thing. In the wards it’s difficult to do that, and being acute admissions, they’re often not there week-in week-out; you don’t have a structured time to sit down with them ... or you could start it and they’re not there the next week; they’ve been discharged, or things have changed.”

(Judy)

The typical experience described here was one in which the participant found their new way of working (SF) to be at odds with the established *modus operandi* of their ward or team (this was typically a problem-focused approach based on ‘solving the client’s problems for them’ in the manner described above in the section on ‘previous practice’). These participants quickly returned to their previous mode of practice.

5.3.6 Overall impact.

The majority of participants claimed that studying SFBT had had a positive impact on their professional identity, their clinical role and, in many cases, their sense of self.

“I think that, because obviously for me, the impact is because ... it’s a very positive ... my feelings that I get from it; it’s a very positive therapy. An energising therapy ... and I kind of, in a way, keep topping myself up, keep myself fuelled up. Y’know,

there's almost a sense that it's good for my wellbeing as well."

(Geraldine)

Many participants felt more enthusiastic about their practice than they had for several years before and this was related to the sense of being able to 'do something' for clients; as one participant, Norma, reflected on her experience, "surely I've got to be able to do more than just be with people when they're miserable."

5.3.7 The Group Narrative

Synthesising all twenty individual narratives into a single group narrative allowed me to create a representative narrative account of the experience of training in SFBT as told by the group as a whole. Obviously, such an account, being more generalisable to the entire group will be less specific to the experience of each individual within the group, this process (although I wasn't necessarily aware of it at the time) does, however, reflect the hermeneutic process engaged with in Stage II of the study. The group narrative is presented below.

"Looking back, before I came on the course my practice was pretty intuitive; it was doing what 'psyche nurses do'; talking to people, trying to be helpful, but not really knowing how I was going to achieve that. It was a sort of 'seat-of-the-pants' approach ... I suppose it was based on problem-solving; the client came with a problem and I tried to solve it! That was my job; we might look at what had helped before, or I might give them some advice, or explain what they were doing in terms of their illness ... a lot of the time it was just being with them, someone to share their discomfort. 'A

problem shared' ... and that sort of thing. I did want to know more ... I wouldn't say that I really worked to a particular model, but I did have some experience of training in other approaches. I used a CBT approach, at times; the Chris Williams stuff, we did SPIRIT training a couple of years ago, and that was useful. It helped to be able to give patients self-help materials that they could take away, you could say, 'Oh this will help your anxiety' or whatever, and you felt like you were doing something. But whatever approach I was using, there was always this feeling that it was up to me to solve the person's problem for them, and that was scary.

So ... I was looking for something else. I didn't really know what, but I was looking for something that would help me do my job better ... another tool for my tool-box, if you will. I didn't really know very much about solution focused therapy; I'd heard a little bit about it and thought it might fit with my way of looking at things. I've always been a pretty positive person, and it made sense to me to be talking about solutions rather than problems but I didn't know how to. I knew there must be more than just what I was doing, but I didn't know what it was ... so when I saw this, I thought I might like it. But I didn't really know what I was getting into, all I knew was it was something new ... and that's what I was looking for.

What did I get from the course ... on a scale from 0 to 10, where 10 is everything I expected, and 0 is I got nothing from it; I would say 10. I got a great deal from the course ... and, in a lot of ways, I got much more than I expected. I certainly got the 'tool' that I could use in practice; that was the main thing I was looking for, but I also got a whole new way of communicating with people. I can do something constructive and positive ... something that makes a difference. And not just with client's; it's something that I can use in my outside life, with managers, and my family ... it's like a 'lifestyle choice' ... and it fitted so well with my way of seeing the world. It just made sense to me. I mean, I'm not saying it was totally brilliant, there were flaws. It would have been useful to have looked more at second sessions and so on ... third and fourth sessions. The course focused a lot on the first session, and although the material was there, I don't think I realised how important the subsequent sessions were. It would also have helped to have realised how difficult it is to apply the approach in ward settings; it's really difficult to apply a

psychotherapeutic approach in the wards, and solution focused is no different in that respect. You just don't have the opportunity to do it. The biggest thing I got from the course, though, was being able to ask clients what they want to change. It's not me that's having to 'find' a solution anymore; it's 'us' working together to find the client's solution. I don't feel responsible anymore for solving the client's problem, they do that themselves now. It's not me telling them what to do, it's them figuring it out for themselves, and that means that they understand it ... they can keep doing it. It works for them, and I don't even have to understand why! And that's such a relief ... I don't think I realised how difficult I found working in the 'medical model'; it was the only thing I had, but this has given me a choice, and it fits with who I am. It just feels natural; I know there's a model behind it, and I understand the model, but it doesn't feel like I'm using a model ... it just comes naturally now. A lot of the time I don't even use the whole model, I just use the bits I need to. It's not like a CBT approach where I have to get a history and then a functional analysis before developing a formulation and so forth ... this is just 'in me'. I can use scaling questions to help the client see where they are and where they want to go, I can use the Miracle Question if it's appropriate, or miss it out if I don't need it. It's the language more than the structure ... and the focus on the future. And even if I'm using another approach, solution focus informs how I do that now. I slip in things that I know will be helpful ... that's the biggest thing for me; seeing that it works! That 'Wow' factor. I've used other approaches and known I was doing it right because I was doing what I'd been taught to do, but with this, I know I'm doing it right because the clients are getting better. They're making amazing changes in their lives, and their telling me that they're better. That's never happened before. And that's given me confidence in who I am as a nurse ... I've got something to give now, I can make a difference. But I can only do that when I'm working autonomously; I can't do it when I'm working in the wards, when I'm part of a team that's doing all sorts of different things. Then you either do what the Consultant wants, or everybody is doing whatever they think themselves ... there's no continuity, and there's so little time to plan therapy sessions, or to carry them out. I don't feel like I'm achieving anything when I try it on the wards ... you don't feel valued then; but when I do it on my own it makes

me feel good, and it makes the patients feel good. Overall, I would say it's given me a completely different mind-set ... it's given me the confidence to do new things; to take positive risks and to allow client's to take positive risks. It's allowed me to use my nursing skills in a positive way, to help people. It might not be for everybody, and it might have to strengthen its 'image' in terms of its clinical evidence base ... but for me ... it's had a significant impact on what I do, and how I think about what I do."

Thus, the group narrative can be seen to provide an emplotted, chromatically structured narrative account of the group's experience of training in SFBT, and provides a context for the narrative analysis presented above.

5.4 Paradigmatic analysis of data.

Following the completion of the narrative analysis of the data from all 20 interviews, the data was then analysed using the paradigmatic analysis technique utilised for the Focus Group data. Transcripts were thematically analysed using an adaptation of Colaizzi's (1978) seven-step formulated meaning model, whereby significant statements were parsed into discrete statements of articulated meaning, and were then identified using a recursive analysis, as contributing to emerging themes. A transcript of one interview is shown in Appendix 4 and the related analysis is shown in Appendix 5. Sixteen individual themes were identified and, from these, five major themes emerged from the analysis. These were: *Client Empowerment, Fit with Personal Values, Success, Framework* and *CBT Based Practice*.

5.4.1 Client Empowerment

The first of these themes, Client Empowerment, can be seen to echo the theme expressed by the participants in the Focus Group, and also echoes the theme of *Trust in Clients* expressed in the Pilot Study (Smith, 2010), suggesting that this is, at least for this group of practitioners, a common experience. There was a sense within this theme of participants being able to recognise that clients, given the chance, were often able to develop their own solutions to problems, and that the practitioners role was to facilitate that process rather than provide the client with answers. This appeared to represent a significant shift in outlook for the participants, from one in which the participant typically provided solutions for the client, to one in which the participant took on a more empowering or nurturing role.

One participant, Anne, described how she had previously worked in a problem solving approach; an approach in which she would discuss the client's situation in sufficient detail for her (Anne) to believe she had identified the client's problem. Anne would then, not only tell the client what the problem was, but would also use her knowledge of similar situations in order to tell the client what to do about solving the problem. Anne reflected that, since completing her training in SFBT, she was now more likely to use SF questions to help the client find their own solutions and, while this might take several sessions, the client was more likely to carry out an action that they themselves had generated. A similar story was reported by Judy, one of the three participants who remained in the study into Stage II. At this stage, Judy recounted how she saw the client taking more *responsibility* for the therapeutic outcome, in the sense that they were empowered to take a less passive role in the therapeutic relationship. Judy had previously described a similar *problem solving* approach to that described by Anne (and most of the other participants) in which she

told the client what to do and how they should be behaving; however, when she was using a SF approach she was aware that the dominant agenda-setting role had shifted to the client. Judy's use of the word 'responsibility' is interesting, in that it suggests that Judy had previously seen (at least some of) her clients as 'not taking responsibility' for their wellbeing. This was a position alluded to by several participants, that clients who had typically 'not taken responsibility' for their wellbeing were now doing so. However, it could be argued that this position of 'not taking responsibility' is the only position open to the client when the nurse (or other practitioner) adopts a position where they 'are responsible' for the client's improvement and wellbeing, such a position as that described by Judy below.

"I liked how you could put it more ... the kind of responsibility, or what the patient's wanting rather than what you're wanting them to do. They're telling you what they're wanting to do, what they want to happen, as part of the assessment rather than what I think they should be doing ... or what level of functioning I think they should have."

(Judy)

Arguably, this new 'empowering' role reflected the growing trust the participant had in the client's ability to find their own solution; it is difficult to imagine how a nurse can empower a client to develop their solution building capacity in the way described above, unless the nurse believes that the client has the potential to do so. While this is a central tenet of SF practice (De Shazer et al, 1986), that clients might have that potential appears to be something that few (if any) of the participants had previously considered. The pre-SF training mode of practice typically described by participants was one in which the nurse held the dominant role of 'care giver' or 'provider' and the client was

the 'recipient' of that care. Participants tended to work "instinctively" (Dawn) without recourse to any specific therapeutic model (Lesley), and while they appeared to feel comfortable in that role it was not without challenges. Some participants spoke of the toll of taking client's problems home with them, worrying about the extent of clients problems and how they, as a practitioner, were going to 'solve them', as reported below:

"As a practitioner, I'd be going home worried about some of them ... or going away and thinking, "My goodness, is that ...", whereas it's a totally different way now, I don't ... it's not like that, it's more ... it's like them accessing it rather than me having to come up with it all the time."

(Jerry)

Participants reported that by empowering clients to take control of their own solutions, the responsibility to provide this was removed from them as therapists. This appeared to be a philosophical change as much (if not more so) than a practical change. Whereas, previously, participants had felt a need to see clients change (or, at least, report back to the clinical team that clients had changed), they were now more accepting that change had to be relevant to the client's situation, and had to be meaningful to the client. That they also now had a theoretical rationale to support this position may have strengthened this position, and can be seen reflected in the comments of Kelly below.

"I don't have that sort of 'heart-sink' feeling about clients anymore. Now I view everyone coming along as having the potential to change. I've a more positive outlook to clients now. ... I do struggle sometimes, though, with clients who don't seem to

want to change. One client; very chronic grief reaction, and I've been working with him for ages, and I've been using it with him. Initially it worked quite well, but over time, it became clearer that this man wasn't at a stage where he actually wanted to change. So I asked him about it at the last session ... and he said, 'I'm content. I'm unhappy, but content.' So I went, 'Right, okay!' I think part of solution therapy is asking 'Do you want to change?'"

(Kelly)

5.4.2 Fit with Personal Values

The second theme to emerge from the interviews in Stage I was *Fit with Personal Values*. In using this term I am seeking to encapsulate the idea that many participants found something about SF practice that fitted with their own pre-training outlook and personal values. This does of course support my prejudicial assumption that participants who had found training in SFBT useful would report an ontological congruence with the knowledge base of SF practice; therefore I approached this theme with some caution, ensuring that there was sufficient evidence to support the conclusion drawn - that *Fit with Personal Values* was indeed an emergent theme. In this respect, Colaizzi's (1978) formulated meaning model was instrumental in ensuring that the integrity of the formulation was maintained. In using Colaizzi's model I was able to demonstrate the process by which I took a specific section of text, formulated a meaning inherent in the text and then linked this to a specific theme, as in the following example from Dawn's first interview:

Transcript	Meaning	Theme

<p>I think it's because it works for me naturally, and it's helped to draw out the confidence issues, it's something that I really enjoy, really like, and I think other people should learn how to do it.</p>	<p>This is an approach that sits comfortably with me. I believe in it.</p>	<p>Intuitive fit. 43.23</p>
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(Extract from Interview 43)

(see specific comments 43.17, 43.18, and 43.30 among others in Appendix 5 for further examples of this process).

Many participants suggested they found that the underlying principles of SFBT resonated with their own pre-existing world view. For some, such as Lauren, this was simply a pragmatic position in which she preferred to explore potential solutions as opposed to analysing existing problems. Lauren suggested that for her, outside of the therapeutic environment, this was a 'common sense' approach to problem resolution and she was pleased to be able to bring this approach into the therapeutic arena. For others, the attraction of the SF model was that it did not *feel like a model*. By this participants described an aversion to working in a formalised style, and a preference for what they perceived as a naturalistic approach. Dawn described herself as someone who did not 'like models' (see Appendix 5, 43.12) and stated that she found SFBT fitted her style of working to such an extent that clients (and presumably, to an extent, Dawn herself) did not feel as though she were working in a model (Comment 43.18). Equally, Lesley found that, although SFBT has a clear structure to it (and the provision of a *Framework* for practice was one of the other key themes to emerge), it felt less structured than other approaches she had trained in. One of the key things to emerge from

Lesley's narrative is that she sees SFBT as a set of 'underlying principles' rather than a model *per se* and, like Dawn, has intuitively engaged with these principles. This suggests that this did not happen in her previous training and that these approaches (Lesley spoke of previous training in Cognitive Behaviour Therapy and Person-Centred Counselling) remained models to be followed, rather than principles to be assimilated, as indicated below:

"I wouldn't say before I did this course that I'd found something that really suited me as well. Y'know, the other course that I've done ... yes; I could take elements from it, but there were probably elements that I thought, 'I'm not keen on that, I don't really like that part of it' or ... whereas with this, because you can just use parts of it ... it doesn't have to be 'you must get a formulation by session whatever' ... it's not, kind of, as strict as that, it's just there's underlying principles that you follow and it's just ... then you can make it your own, sort of thing. I've found that very useful, and it suits me better than some of the other things I've done."

(Lesley)

5.4.3 Success

The connection between *Success* and *Fit with Personal Values* was reflected on by Teresa, who implied that she had been unaware of just how dissatisfied she had been with her traditional mode of practice until she began to work in a SF way. It was her experience of satisfaction with both the process and outcomes of SF practice that prompted her to ask why she had not seen these successful outcomes previously, and to question the usefulness of the 'medical model' approach she had previously been trained to work in.

"The medical model doesn't sit well with me; but I don't think I knew that until I started the solution focused stuff. I just thought, 'This is what we're supposed to do', and I just thought 'This is what we're expected to carry out'; and y'know I didn't realise I wasn't happy with that. It was doing the course that made me question, 'Is this working?'"

(Teresa)

Other participants spoke of their surprise at the positive clinical outcomes they were seeing since they began working in a SF manner. Emily spoke of her delight at being able to help people, "It really, really works, and that's what's changed for me." The obvious implication here is that Emily's previous mode of practice did not seem to 'work' as successfully for clients, and that this was not seen as 'unsuccessful' but rather, represented the norm in terms of clinical outcomes. This was echoed by Lesley, who noted that "It works!" and that had not been the case with her previous training experiences, as reported here:

"I saw how it worked, and I saw how the patient's responded, and I suppose that made me think, "Oh, this is amazing", y'know – It Works! Which was the experience I didn't have with CBT. It was like "Yeah, okay; I did it", but it wasn't like "Wow, these people are getting better ... and it's fantastic" ... which is what I felt SFT was like. "Wow, I can do something here that's really making a difference" or "the people here are doing something that's really making a difference"."

(Lesley)

This experience of success not only led participants to continue using SFBT but helped to reinforce their sense of professional identity, in

that they were seeing themselves as 'someone who can make a difference'. Some participants had been able to set up and run a SFBT Clinic (Barbara), while others were simply pleased to 'show off' their newly acquired clinical skills to students and trainees (Janet).

5.4.4 Framework

The fourth theme to emerge was that SFBT training had provided participants with a framework for practice. Where previously most participants had relied on their own intuition to know how to respond to client's problem narratives (Dawn); leaving many of them feeling vulnerable and overwhelmed, rather like a magician producing 'answers', like rabbits from a hat (Drew), SFBT gave practitioners a structure around which to build their conversations. Participants spoke about *the process* of solution building (of co-constructing solutions with clients) and how 'knowing what to do next' (Karen) removed the burden of having to come up with a solution for the client. This sense of using technique and (what could be described as) formulaic interactions in SFBT was recognised by Steve De Shazer, in a privately published paper, in which he discussed the criticism (by some traditional therapists) that SFBT was heavily dependent on techniques and formulaic ways of talking to clients, as stated here:

"First of all, I simply want to agree with the observation that most of brief therapy, including SFBT is "heavily dependent on techniques." Of course. What else? Technique is the "foundation" of doing SFBT. Second, then, I wonder how can this be a criticism? What would a therapy be like that did not fit this description? I guess that this would mean that the therapist does whatever she or he feels like doing."

(De Shazer, 2002.)

This would appear to be the position that many of the participants had found themselves in previously; or rather, they found themselves in the position of doing *what they felt they ought to be doing*, without necessarily knowing what that was. The provision of a theoretical framework removed the need to 'pluck things out of the air' (Judy) and allowed participants to legitimise their own way of working (Michael, Dawn) and structure their work with clients (Karen, Drew).

5.4.5 CBT Based Practice

The majority of participants had some experience of CBT-type therapeutic work, arguably reflecting the near paradigmatic status this approach has come to have within mental health care. SPIRIT training (Williams and Garland, 2002) had been delivered across one of the major sites where SFBT training had been delivered (SPIRIT training was delivered before SFBT training) and to selected staff in the other major site; thus, most participants were aware of the approach and many had used it in practice. Experience and opinion of the approach varied, from dislike and avoidance of the approach (Dawn) to acceptance and use (Norman), but rarely with the sense of enthusiasm and personal fit as participants used in relation to SF work as reported by Lesley.

"I knew that CBT was okay, but it didn't particularly sit with me that well ... it didn't suit me that well, although I used elements of it, and it was useful, but I didn't want to go and do CBT therapy or anything like that."

(Lesley)

This may be due to the fact that the SPIRIT training (in various guises) was delivered to most participants over a period of one to five days, thereby precluding an in-depth understanding of CBT in its own right. Only a few participants had completed a more extended training in CBT; however, while having an in-depth understanding of the model, they continued to describe a closer personal fit with the SFBT model than with the CBT model (Lesley, Ellen).

5.4.6 Additional Emerging Themes.

In addition to the five major themes addressed above, a number of minor themes were also evident. These included a previous reliance on Problem Solving, the utilisation of SF skills in other aspects of the participant's lives, the degree of personal change they had experienced, changes to their sense of professional identity, and in their trust in the clients they worked with. The first of these themes has been alluded to above in relation to participant's previous practice (5.3.1). Many participants spoke of working in an *ad-hoc* manner, utilising their own experience and intuition in order to suggest possible solutions to their client, for example Eleanor described her early practice as "pretty much feeling my way" , going on to outline how she would typically be,

"trying to find what works for particular patients and ... trying to just kind of establish relationships. A lot of just finding your own way, and ... y'know, hopefully because of the other skills I had, I was using, applying these ... sort of basic clinical skills that mental health nurses have – so it would have been a more generic type approach again."

(Eleanor)

Of note is the tenuous quality of what Eleanor is saying, she is clearly thinking the story through as she proceeds; this is not something she has necessarily considered before. A similar style of narration was evident in the reflections of Agnes and Drew (among others). Norma spoke of how she felt she had come to rely on the 'props' of problem solving as an alternative to actually engaging with the client.

"It really tied in, actually, at that time, quite well, with my busy, problem-solving nurse, because you have all your papers, and you have your sheets and you have your boxes and you have your pens, and sometimes you have coloured pens, and it's, y'know, fabulous, I love it! (laughs). But, I was in danger of becoming too prop focused. I would say I've improved on that."

(Norma)

Inherent in this account is the implicit need to be seen to be 'doing something' to help the client (or at least, provide the illusion of this). It was this sense of having to "pull rabbits out of hats" (Drew) and provide solutions to client's problems that many participants found personally draining, and which SFBT provided a welcome relief from.

However, it was not only in professional practice that many participants experienced benefits from SFBT training, several participants spoke of how they had come to utilise SF techniques in other aspects of their lives. Eleanor and Perry both described how they utilised techniques such as building a positive future scenario or scaling small steps of progress with their managers and colleagues, to

successfully turn conversations about 'the same old problems' into conversations of change and 'how we'll know things have started to improve'. Similarly, Geraldine, spoke of incorporating aspects of SFBT in her family life and the recognition of this change in their conversations.

"One thing that's changed, that my family have noticed, is that on a personal level ... I seem to be using more positive language. On a personal level. It's your fault! (laughs). I think my husband said, 'Oh, we've got another 'Wow' there, Geraldine'. Okay!"

(Geraldine)

Dawn equally spoke of using some 'not knowing' techniques when helping her teenage son make important decisions; the key point being that she *helped him* to make the decision for himself, rather than making it for him. This experience of informally utilising therapeutic techniques outside the therapeutic setting was clearly a new one for these participants.

"It started to seep into work, staff, friends, family ... just, people that I'd meet, it just became a completely different way of communicating with people. It just seemed like an entire shift in perspective, in the way that you interact, in the way you relate. I didn't just learn a therapy, I learned to communicate ... (pause) ... which was kind of huge for me actually"

(Norma)

Another significant shift for several participants was a shift in their sense of professional identity. Dawn spoke of feeling like a professional 'dinosaur' prior to undertaking her training, and Ella described a sense of sense of inferiority when considering her previous skill set:

"I've only done pretty basic training ... I'm a nurse, I'm an R.M.N. is my background, so my skills ... my skills were still transferable, but it was a very basic level, the SPIRITs materials and stuff like that ... so I would say it's [the training course] definitely energised me and I'm looking at it [clinical practice] completely differently."

(Ella)

Both expressed a renewed sense of professional identity following the training. In a similar manner, Lesley spoke of acquiring the confidence to apply (and get) a new job following the course, something she would not have done previously. In a related manner, Jerry described how she had now found the confidence to demonstrate SFBT techniques to students and colleagues.

"I will say, I've shown off a wee bit actually, because at times, obviously we get students, and at times I will actually do a kind of solution focused therapy session, probably a full session, just to kind of demonstrate the difference, I suppose, with the, sort of, CBT sort of approach. I've even done that with a medical student actually!"

(Jerry)

There is (for me, at least) a tangible sense of achievement and pride in Jerry's account, the 'even' in the final sentence suggesting her own sense of awe at doing something she would never have dared do before. There appears to have been something about 'being able to make a difference' that energised and empowered participants in relation to their practice, and their sense of being a practitioner. Dawn encapsulated this in her account of a conversation with another student in her cohort,

"I remember when we'd finished the class and Perry and I were having a talk; and both of us have got long service, and he says "I wish I'd known about this thirty years ago", and I said, "I wish I'd known about it twenty-five years ago", because at least then we'd have been doing something constructive with our clients all these years."

(Dawn)

Inherent in this statement is the meaning that Dawn has moved from feeling 'like a dinosaur' to being a competent professional who can 'do something constructive' with clients; with the implied caveat that she hadn't been achieving this previously.

Possibly as part of this change in professional identity, several participants also spoke of a change in the way they related to their clients now. Specifically, they expressed a greater degree of trust in their clients judgement and strengths than they had previously perceived. Both Kelly and Caleigh spoke of 'learning from the client' in the sense of not assuming that they 'knew best', but in *allowing* the client to explore their own options and determine their own goals. Neither participant had previously considered the power they exercised over clients, nor how iatrogenic such an approach may be. Norma also

recognised that she had developed greater respect and faith in her clients abilities, and reflected on her previous attitude.

“At times I could be a bit quick, a bit sharp, a bit ‘well, if that’s not working, they’re not trying hard enough’, y’know. I was that quick to think, ‘well, if it’s not working, they’re not doing it right’, y’know. And yeh, you’ve got a tendency; you’ve got a lot to do, you’ve got a lot to get on with and you’re like, ‘they’re not trying hard enough’, ‘I can’t think of any other way to do it, it must be them’. But now, now I don’t think that, now I think, ‘well, it’s not right for them’. Then I haven’t listened, I need to go back and listen. So I think, yeah, that’s really helped.”

(Norma)

There is a clear sense here of not only a trust in her client’s efforts to change their situation, but a recognition of the blame culture that she previously subscribed to. As a nurse her frustration when clients did not improve appears to have been directed back at the client, blaming them for a lack of progress which, conversely, she felt it was her job to produce. The second-last sentence in Norma’s account reflects a key learning objective of the SFBT training course; that if therapy is not working, the problem is the therapists, not the clients, and therefore the therapist has to do something different. This appears to have been a message that Norma and her colleagues took to heart.

5.5 Typology of Experience

As I began to gain some understanding of *what* the experience of the participants had been, and cognisant that I wished to ask *why* they had had that experience, I was aware of an emerging pattern of

responses relating to participants' use of solution focused therapy, their clinical context in terms of location and autonomy of practice, and the extent to which their expectations of training were satisfied. In order to better understand the scope of that experience and to enable the selection of participants for the second Stage of the study I undertook the construction of a typology that highlighted four specific domains of experience (see Table 1); high level of satisfaction with the course experience, low level of satisfaction with the course experience, a high level of autonomy in practice, a low level of autonomy in practice.

A subjective rating of the course experience as providing a 'low level of satisfaction' was attributed where a participant rated their experience as less than '8' on a scale of 0 to 10 during their interview. Correspondingly, a 'high level of satisfaction' was attributed to a rating of '8' and above on the same scale. (While an arbitrary decision on my part, this allowed a sufficiently high benchmark to mitigate the potential for respondent bias in participants.) In all there were three participants who perceived a 'low level of satisfaction' with their experience, and seventeen participants who reported a 'high level of satisfaction'.

Feature	Commonly expressed as	Number of participants
High level of autonomy	Community based work	17
Low level of autonomy	Ward based work	3
High level of satisfaction	Rating experience ≥ 8	17
Low level of satisfaction	Rating experience <8	3

Table 1: Typology of experience of research participants.

In terms of the latter two domains in the typology, seventeen of the participants reported working in some form of autonomous role, usually as some form of Community Nurse in which they had their own caseload and the freedom to interact with clients in a model of their choosing. Three participants, however, reported working in a team setting (two were part of a ward team, and one was part of a larger, integrated team of practitioners running a clinic) and, as such, had lower levels of autonomy than their counterparts in the study. As *being able to use* the SF skills acquired on the course had been seen to be an issue related to participants' satisfaction with the training experience, it was perhaps not surprising that there was a direct link between the nature of a participant's work environment and the level of satisfaction they experienced. The three participants who reported a 'low level of satisfaction' from their experience were the same three who practised in a role with low autonomy.

Having identified what I believed to be a link between working in a ward/team based setting and low levels of satisfaction from working in a SF modality, this became the focus for Stage II of my research.

“What was the experience of nurses working in a ward/team setting in relation to training in SFBT, and did that differ to the experience of nurses working in an autonomous setting?”

In approaching this question I was aware that one of the original three nurses (Judy) who worked in a ward/team setting had now moved to an autonomous role, and also that one of the original seventeen autonomous nurses (Dawn) had now moved into a ward/team role. I was also aware that another of the original seventeen autonomous nurses (Lesley) had only moved into that role a short while before the

initial interview and had a great deal of experience in ward/team work. Therefore, as these three participants had (as far as I was aware) the broadest range of experience relevant to my question, I asked them to participate in Stage II of the project. Moreover, I asked another of the original three nurses (Rachel) who worked in a ward/team setting to participate (this would give me two nurses who reported a 'low level of satisfaction' and two who perceived their experience as offering a 'high level of satisfaction', adding further balance to the selection), however she did not respond after two requests and so I accepted that she did not wish to participate further. I then contacted the third participant in this group (Ellen), but received an email by return saying she no longer worked for that organisation. I therefore went into Stage II with three participants; Dawn, Judy and Lesley.

Chapter 6: Discussion on Stage I.

6.1 Chapter Overview

In this chapter the issues raised in Chapter Five will be discussed more fully. Issues surrounding participant's previous practice will be explored and the implications of this will be discussed in relation to the wider literature. It will be suggested that current models of practice place nurses in a 'double-bind' in relation to their own professional practice, and that SFBT can offer a pathway forward for some practitioners. Finally, it will be suggested that SFBT provides a pathway to the genuine engagement with clients envisaged in contemporary health and social care policy and legislation.

6.2 Former Practice

The analysis of narratives provided by participants in Stage I clearly describes a 'before and after' scenario in which participants express greater satisfaction with their post-training practise than with their pre-training experience. Assuming that the themes emerging from the paradigmatic analysis represent 'news of difference' (Bateson, 1979) then, arguably, these narratives tells us as much about the participants pre-training practice as about their post training practice. Despite their apparent reluctance to discuss pre-training practice in detail (see section 5.3.1), it can be assumed that many of them found their practice did not empower their clients, did not fit with their personal values, was not successful, lacked a coherent framework and was, to some extent, influenced by CBT orientated ideas. If this were the case then it is understandable why participants were reluctant to

describe this in detail, and why those who did provide greater detail (Dawn, Kelly, Geraldine) expressed frustration with their practise at that time.

One, broad-based, area of agreement was that nursing practice was based around problem solving activities. Nurses spent time with clients, got to know them and established a *therapeutic relationship* (interestingly, this therapeutic relationship was often presented as an end in itself, as opposed to a means to an end), through which interaction the client was expected to recover. There is a sense in this of providing a form of pastoral support, of *being with* the client in their time of distress and helping them navigate their way through the rough sea to calmer waters (Barker, 2001). Several of the participants (Agnes, Norma, Eleanor) stressed the importance for them of building relationships with clients:

“Relationship is extremely important, I’ve always had that, I’ve always been able to develop relationships with patients ... I’ve always felt I had ... good practice to make people change, whatever the problem.”

(Agnes)

However, this description of practice is only one part of the pre- SFBT training narrative recounted by participants. While this narrative surfaced when speaking about their own previous practice, when participants spoke of their wider practice experience they tended to speak more of the needs of the teams in which they worked. This alternative narrative described the team role that nurses play, and in this role nurses responded to the requirements of the team, often performing tasks associated with ward administration or patient ‘observation’. Many of the participants (Perry, Judy, Lesley) spoke of

the competing pressures of their role as a senior nurse and their role as a clinician:

“I was a senior nurse, so I suppose ... you did have a lot of responsibility, but just to a point; it was always to a point. Because you weren't really totally autonomous; you had to do what the Psychiatrist told you, which is probably what I found difficult!”

(Lesley)

This, of course, is not new. Arndt (2009) has discussed the role conflicts experienced by 'nurse superintendents' in early twentieth century hospital care, highlighting the competing pressures on the nurse to be a practitioner, an administrator and an educator, while showing due "consideration and respect for the physician's rights and privileges" (p. 134). Coombs and Ersser (2004) found this medical dominance over nursing care remained a feature of clinical care in the early twenty-first century in a multi-disciplinary study where medical participants spoke of 'bequeathing' certain aspects of patient care to nursing staff (p. 248). Pearson (2003) has argued that "role confusion and role conflict have become endemic in nursing" (p. 626) as a result in the changing roles of nurses, doctors and allied health professionals. In the mental health arena, Crawford et al (2013) found that the language of contemporary mental health nursing care, even when it ostensibly related to person-centred care, reflected a process-focused mind-set. In analysing the language used by their participants the authors identified three dominant patterns.

“First, there was a marked depletion in language related to attributes of a compassionate mentality. Second, language use concerning paperwork, processing, and time, connoting a production-line

mentality, intruded substantially into practitioner constructions. Third, the language indicated an institutional mentality and emotional distancing between practitioners and patients.”

(Crawford et al, 2013. p. 721.)

6.3 Models of Practice

Clearly the experience alluded to by the participants in the current project is not unique, nor is it exclusive to the present day. There is, in the accounts provided by participants in the current study, something of a paradox between the theoretical, or idealised, basis of nursing practice and the actual lived experience of practice. In the former the nurse ‘walks with the patient’ and functions as a therapeutic healer, in the latter the nurse responds to the needs of nursing colleagues, hospital administration, psychiatrists, those patients deemed most ‘at risk’ and the unarticulated demands of ‘the team’. Recognising the ‘ideal in the actual’ (Suzuki, 1999), and vice-versa, is clearly a challenge in contemporary mental health nursing practice. However, it could be argued that the challenge is intensified when one considers the dominant models available to the practitioner.

The ‘actual’ practice experience can be described as a clinically driven, medically led administrative process typified by the ‘medical model’. In this approach nurses administer medications, observe patients for positive or negative reactions to this, ensure patients do no harm to themselves or others, and maintain comprehensive records of their interactions. The alternative generally available to practitioners (the ideal practice experience) can be termed the ‘psychological model’, where nurses engage clients in *psychological therapies*, or *talking therapies*, such as CBT (Gellatly and Molloy, 2014; Stevenson and

Sloan, 2012), and Interpersonal Psychotherapy (IPT) (Crowe et al, 2012; van Schaik et al, 2007). In this approach nurses deliver interactions based on psychological interventions, interactions usually based on brief training experiences (Norman, Lesley, Geraldine) and without the underpinning assumptions and beliefs inherent in the psychology model. There is, for me, an obvious question here: where lies the 'nursing model'?

I would argue that training nurses to deliver interactions based on the epistemology of professional disciplines other than nursing runs a significant risk of producing practitioners sufficiently skilled to carry out specific tasks related to another profession, but without the contextual professional understanding necessary to *own those skills*. In other words, they become 'medical technicians' or 'psychology technicians' – semi-skilled assistants 'bequeathed' clinically less important tasks by their professional masters. This offers a clear 'double-bind' (Bateson, 1972) to the nurse practitioner – 'in order to progress your career as a nurse would you prefer to become a medical technician or a psychology technician?' That many nurses appear to be happy to accept this choice may well reflect the socialisation of nurses' expectations by their more powerful colleagues, and the ever present attraction of 'management' (and education) as a 'nursing' career alternative – the 'womanly' tasks of administration and organisation have always been seen as laudable (Arndt, 2009), and it should be remembered that some of the key roles undertaken by Florence Nightingale's 'trained nurses' were as administrator and trainer (Dingwall, Rafferty, Webster, 2002). In so far as clinical interactions are concerned, the question "where lies the nursing model?" is a valid question, and one that may underpin the sense of dissonance expressed by the participants in this project.

6.4 Where lies the Nursing Model?

For those participants who experienced a high degree of satisfaction with their SFBT training experience, I would suggest that 'the nursing model' lies in SFBT. As discussed in Chapter Two, the literature on SFBT has always argued that this approach is congruent with the values of nursing (Hillyer, 1996) and can empower nurses to deliver the 'care' to clients that is the essence of nursing practice. Two decades ago, Montgomery and Webster (1994) argued that,

"Shifting from a reliance on psychological or biomedical models to a nursing paradigm can provide nursing with a framework to guide practice and to select and integrate theories arising outside of our own discipline."

(p. 291/292)

They concluded that as mid-'nineties health care became more consumerised, the time was ripe for nurses to "reclaim the source of power and excellence contained within our own values and our own science" (Montgomery and Webster, 1994. p.296). However, it would appear that rather than being at the forefront of a debate exploring the future of a distinct nursing epistemology, they represented the final echoes of a debate on 'nursing models' which had flourished in the 1980's but was shortly to be replaced by a more utilitarian debate on the efficacy of differing interventions – the focus shifting from the practitioner to the practice. It has to be recognised, however, that SFBT is not 'a nursing intervention' *per se*. As discussed in Chapter Two, the roots of the approach lie in family-therapy and in social-work practice; however, as an egalitarian, co-operative and empowering approach (Webster, 1990) it is congruent with the practice of a range

of health and social care disciplines, including nursing. That it has enabled many of the participants in this study to renew, and engage with, their passion for mental health nursing practice is not surprising, and is not limited to only this group of practitioners. A range of health and social care practitioners trained in SF techniques by The Thistle Foundation in Edinburgh described the approach as “affirming”, “hopeful”, “invigorating” and “enlightening” (Thistle Foundation, 2011) and go on to describe many of the same outcomes, in terms of practice, home life, satisfaction and success, as those described by participants in the present study. Cunanan and McCollum (2006) found similar outcomes across a range of SF practitioners in the USA, one participant described part of her experience thus:

“I came out of the home visit feeling awesome and I remember saying to myself, ‘NOW, I feel like a real dietician!’ It only took 13 years! In all of my training around counselling and education and communication, nothing ever equipped me as well as SF.”

(p. 61)

It can be seen that for practitioners in a range of disciplines out-with the dominant biomedical or psychological frameworks, SFBT offers a paradigm which enables them to work collaboratively with clients in a consensual, concordant manner (I am, belatedly, struck by the parallels with concordance-based working [Snowden et al, 2014] inherent in this approach). Certainly, for the participants in this study, SFBT provided an alternative to the medical model and the psychological model of practice, allowing them to practice *as nurses*, echoing one of the comments made by a participant in the Pilot Study – asked to summarise her experience, the participant responded:

"It's made me a nicer nurse!"

(Smith, 2010. p. 109)

6.5 "It Works!"

One of the most remarkable things for many participants was that SFBT 'worked'! Worked in the sense that clients 'got better' (many of the participants, while recognising the social constructivist nature of SFBT practice and it's congruence with their own personal outlook, continued to utilise medical terminology associated with an illness model), and did so in a remarkably short space of time. Despite the evidence base in the literature (Macdonald, 2007) suggesting that typical treatment times were three to five sessions and, indeed, that SFBT was by definition a 'brief' therapy, this came as a surprise to many participants. There is a sense that client's 'getting better' at all was something of a departure from the norm, arguably reflecting a dominant experience within mental health nursing of *observing* and *assessing* patients, *maintaining* them at their optimal level of function, *monitoring* their progress (or lack of) and *reporting* this back to a wider team, over a prolonged period and with no real expectation of significant change. This understanding is supported by comments throughout the research project: from the pilot study prior to the project proper, through the 'success' theme found in the focus group interview and in the various individual comments on 'success' discussed in the Chapter Five.

"I heard you talking about treating people in one session, I thought 'other people maybe, not me. Psychiatry has its limits!' Now I'm amazed when I do it in one session",

(Participant 3, Pilot Study)

Norma, Teresa and Lesley all spoke clearly of this sense of futility in their previous practice, a practise that appeared to promote the virtue of sharing the client's distress, but to no obvious outcome.

"That kind of, 'wading through treacle' ... just being with people when they were miserable and, surely I've got to be able to do more than just be with people when they're miserable. I hoped that I would be able to do more than just sit and be miserable with people."

(Norma)

Training in SFBT provided these practitioners with a formal, structured framework within which they could make a difference to people's lives. This, in itself, was a major outcome for those practitioners. The manner in which it made a difference was also significant.

6.6 Trust

Many of these practitioners had a significant amount of clinical experience behind them, some like Dawn and Perry had twenty-five and thirty years' experience, others like Geraldine and Norma had over a decades' experience. Almost all of them were surprised to note how little they had come to trust and respect (other than at a superficial level) the patients they worked with. The cultural norm that they described was one where patients were 'not to be trusted': not to be trusted with the practitioners safety, not to be trusted with their own safety and not to be trusted to *really try* to get better (to take their medication, to adhere to their treatment plan, to *do what they were*

told). Possibly this should not be surprising, Foucault, Baudot and Couchman (1978) argued over thirty years ago that, since the beginning of the nineteenth century, it is the unpredictability of the behaviour of *the other* that defines the social (and legal) construct of 'madness', by definition - 'the mad are not to be trusted'. This was not, however, a message they had explicitly come across. It implicitly permeated almost everything they did in practice, but was submerged in an explicit message to the contrary, a rhetoric of rights, relationships and recovery. Thus, it came as a shock to many of these practitioners when they discovered what happened when they did, actually, begin to trust the people they worked with (I'm reminded here of Norman's comment that many people say they work this way, but when you look at it, you think, 'well - how?' and of Teresa's comment that she never realised she had problems with her previous mode of practice 'until I started the solution focused stuff').

This was a major breakthrough for these practitioners; that you could really trust the client's you worked with, and they would respond positively. By *working with* the client the practitioners were able to circumvent the problems of telling the client what to do and, through the adoption of a 'not knowing' stance (De Shazer et al, 1986), ask the client what they thought would be helpful and work with the ideas generated by the client. This has, of course, been identified in the literature, and was a central theme of the early descriptive literature relating to SFBT practice. Sykes-Wylie (1990) quoted from a conversation with Ronald Taffel,

"What he [a previous client of Taffel's] remembered, in fact, was that I was the first person who talked straight to him, at a time when he was finally ready to change. This may ultimately be the answer to our 'quick successes.' We help only those people who give us permission to do so."

(p.31)

Sykes-Wylie appears to be proposing here that by 'seeking the client's permission to change' the therapeutic dynamic is changed from a coercive relationship to an enabling relationship, thereby requiring not only that the therapist 'trust' the client, but that the client respond to that trust in a positive manner. Iveson (1993) argued that:

"the therapist's task is to join with the client in a mutual exploration of the client's world. This requires not a belief in the truth of this world but a respect for the client and a genuine interest in his or her view."

(p.13)

This sense of *joining* with the client in a spirit of *respect* and *genuine interest* was not a new concept to the participants in the study, what surprised them was that it was only once they had begun to practice in a SF manner that they realised how minimally their practice had endorsed these principles previously. It can be seen that training in SFBT has helped these practitioners practise in a manner that is congruent with UK and Scottish Government directives (Department of Health, 2010; Scottish Executive, 2006), professional standards (Nursing and Midwifery Council, 2015) and best practice guidelines (NHS Education for Scotland, 2011b; Scottish Recovery Network, 2013) for nursing, but more than that, it has enabled them to use their nursing skills in a positive manner to the benefit of the client's they are working with.

It can be seen that the overarching experience for these participants was one where SFBT provided an alternative approach to the dominant epistemologies of the 'medical model' and the 'psychological model' of care (reflecting the formulation described in section 1.6). Not only did the SFBT training experience provide an alternative mode of practice for these participants, in keeping with the literature, it provided an approach that works successfully in practice (Wilgosh et al, 1993), enhances nurses professional identity (Montgomery and Webster, 1994) and is easily incorporated into nursing practice (Chambers et al, 2013). Why this should have been the experience for most of the participants in the study, but not for others, is explored in Stage II of the study.

Chapter 7: Interpretation of Texts (Stage II): Dawn

7.1 Chapter Overview

This chapter will begin with an overview of the hermeneutic process adopted in Stage II of the study. I shall then provide an interpretation of the text of my interview with Dawn; beginning with a review of my background relationship with Dawn, I will then thematically analyse the text, using specific examples to illustrate and support the analysis. I will then provide my interpretation of the text, arguing for key points of understanding emerging from the interpretation, and concluding with a clear statement delineating my understanding of Dawn's experience.

7.2 Process

The format of the three interviews with Dawn, Judy and Lesley is described in Chapter Four. As in Stage I, in order to avoid patterning interpretations of future interviews no attempt was made to analyse the data from the interviews until all three interviews were completed. However, shortly after each interview, I completed a reflective exercise in which I reflected on my experience of the interview. Having completed all three interviews I undertook an interview with a member of my supervision team, in which I was interviewed using the same anchor questions as I had employed. Following this interview I, again, completed a reflective account of my experience as an interviewee.

Following this preparation, I began to analyse each of the Stage II interviews. Audio tapes were transcribed and the transcript text was analysed using the same narrative and paradigmatic techniques as were employed in Stage I. Having identified themes emerging from these narratives, I then spent several months immersing myself in these texts. This was a process which, while not defying description, I find very difficult to describe. In seeking to engage with the *otherness* of the texts – to experience from them something new, something I did not already know – I was aiming to occupy a ground between *understanding* the texts (in which case I would have consumed the *otherness* of the text and made it my own) and *accepting* the texts (in which case I would have surrendered my horizon of experience to the *other*); in other words, to engage in a dialogue with the texts. Davey (2006), in his fourth thesis on philosophical hermeneutics, states that,

“it is not sameness – neither rendering the other the same as ourselves nor becoming the same as the other – but difference that is vital for philosophical hermeneutics”

(p.7).

He argues that the act of subsuming the other into one’s own voice effectively changes a dialogue into a monologue, while the act of suspending one’s own horizons and entering the other’s way of being is to temporarily abandon one’s own way of knowing. This is what I sought to do; to enter into a dialogue with the texts, from which to derive *an understanding* that, while not certain, was ‘possible and probable’. In this I was guided by Gadamer’s statement that,

“The idea is always that what is clear is not proved and not absolutely certain, but it asserts itself by reason of its own merit within the area of the possible and probable.”

(1979, pp.441/442)

During this process of immersing myself in the texts, I formulated a series of guidelines in response to my question (to myself), ‘how can I be the best audience for each participant?’ These guidelines included:

- Listen to what she is telling me (through the text).
 - Recognise that she is being the best narrator that she can be – what does she need from me to help make her meaning clear?
- Work with the original text.
 - What are her primary answers (as opposed to secondary, explanatory statements)?
- What are the themes of our conversation?
 - What informs these themes?
- Stay text-focused – avoid ‘red herrings’.
 - Intuitive interpretation must be based on the text.
- Be prepared to own my own interpretation.

With these guidelines in mind, I read and re-read the texts, asking what they were trying to tell me. Each attempt at deriving meaning from a part of the text was then explored, the ideas developed and compared with the text as a whole, and then usually discarded as being incompatible with the whole. Over time, however, the small pieces of meaning that I had retained amalgamated into a larger understanding (in the sense of a [speculative] understanding as opposed to *the* [definitive] understanding) of each text, until such time as I felt that I had genuinely learned something new from each text,

as a result of the fusion of horizons between the text and me. In ending this process of dialogue with the texts there was a personal sense of rude termination; while knowing that I had to move on to the next stage of the project, I had a sense that there was still more I could learn from the texts, that there were further conversations to be had. This is, of course, true and while pragmatically necessary, the observation reflects Gadamer's assertion that there is no 'tedium' in engaging in a dialogue of this nature; the longer we stay with a piece of work "the more it displays its manifold riches to us" (Bernasconi, 1987. p45). Having come to an understanding with some of the riches contained in these texts I now felt able to present an interpretation of why these participants may have had the experience of training in SFBT that they did. These interpretations are presented below.

7.3 Dawn: Background

Dawn is an experienced Staff Nurse, in her mid-forties, with many years of experience in both Ward-based and Community-based mental health nursing. She comes from a healthcare family; her mother was a mental nurse and she grew up in and around psychiatric hospitals. She describes not knowing what she wanted to do when she left school and essentially drifted into nursing after signing up to a 'hospital cadet' role. This was convenient as she was living in her parent's hospital accommodation which brought her into contact with a number of diverse roles within a hospital community. She did not enjoy her experience of laundry work, or office work, but found 'ward work' suited her;

"I worked in loads of different departments, wards included, and wards was the ones that I enjoyed the most. It had lots of people contacts ... It was working alongside people, trying to help them understand themselves I suppose."

(Dawn, 25)

Although she found working with 'people in wards' satisfying, she quickly discovered that her interest in people brought her into conflict with some of the expectations of her 'superiors' as to what was expected of a Nurse.

"But there was always a kind of rebel bitty inside of me that wanted to help the patients to help themselves and I was forever getting in to trouble in my training for talking to patients ... The amount of times I spent in the sluice scrubbing it was unreal, because I spoke to the patients."

(Dawn, 32)

I first met Dawn when she started the SFBT training course several years ago. Since then we have become colleagues in the SF community. We have attended conferences together, and Dawn is active in promoting SF practice in her practice area. When she commenced her SFBT training she was working as part of a Community Mental Health Team in a largely autonomous role. Since then her role has evolved and she is now working in a ward setting as part of a multidisciplinary team. According to my prejudicial expectations, based on my interpretation of the typology of experience in Stage I, she would be likely to be finding it much more difficult to apply SF practices to her care, and be less satisfied with the outcomes of her training experience, since she had moved from her community role to her new role in a ward setting.

7.4 Analysis of Text

Analysis of the text of Dawn's interview revealed a number of emergent themes (see appendices 7 and 8). The major theme to emerge from the interview was Dawn's belief that *she saw people as 'people'* and not as 'patients'. This was inherent in much of the reason she had become a nurse; she stated that she wanted to help people 'understand themselves' better and, as a result of growing up in and around a psychiatric hospital, she saw beyond the strange behaviour and diagnostic labels people in the hospital often presented to the world (the 'other-ness' of the patient) and saw through to the person-with-the-problem rather than 'the-person-as-a-problem'. She, thus, sought to engage with the 'person' at a personal level, but recognised that this was (to some degree) at odds with a traditional Nursing orthodoxy, and on occasions had caused friction in her relations with more senior members of staff, as reported here:

"I wanted to know more, understand more, understand why people were the way they were. Or, have an understanding, not understand. And go from there and see what I could learn ... I'd always seen people with mental health issues as people, didn't see their illness, they were just people to me."

(Dawn, 25)

A second major theme to emerge from Dawn's interview was that she saw SFBT *fitting with her ontological perspective*. She spoke extensively on how the practice of SFBT was similar to the way she had practised before training in the approach, and how the assumptions underpinning the approach reflected her own world-view. She related this to her experience of training in other approaches,

particularly CBT and THORN (a CBT-based initiative for working with people with psychosis), where she believed there was an excessive focus on 'problems' and the patient's/person's weaknesses and deficits. This felt, she said, like she was "knocking them down to build them up again". In SFBT, she believed the therapist's role was one in which she heard the person's 'problem story' but did not "do nothing with the story, you take them from where they are now" and focus on the future. This was something she had found in her first exposure to SFBT, on a two-day workshop, and felt that this egalitarian and strengths-based approach which better suited her outlook as a professional, as given here:

"I've had a taste of THORN, I've had a taste of Motivational Interviewing, various other ones that I can't remember, and none of them really suited me as an individual; so I was getting pretty disheartened until I did a one-day, not with yourself, it was with somebody else, on solution, I did two days with them. It was a two-day course and a year later your course came up. And that's when I applied for it."

(Dawn, 45)

Given Dawn's assertion that she had always worked in a manner congruent with the principles of SFBT, the third theme emerging from the text is, perhaps, not surprising - that training in SFBT *provided structure* to her practice. Although Dawn described herself as always having worked in a SF manner ("I suppose it's always been the way I've worked"), she also described this way of working as being largely intuitive and lacking a formal structure, or evidence base. This was something that left her feeling vulnerable and 'like a dinosaur' in terms of her professional relationships with younger staff. This sense of being 'like a dinosaur' is one that Dawn has alluded to throughout the

various stages of the interview process, she referred to it in her Stage I interview, where she stated:

"I was feeling I was a bit of a dinosaur in the service.
All the youngsters coming through,
knowing all about models
and everything like that;
I mean I hadn't a clue
what they were talking about
half the time."

(Dawn, 42.21)

and again in Stage II:

"I suppose because I'd been trained for so long,
including me 'E.N.' training, I was getting to be a bit
of a dinosaur and I was getting a bit disheartened.
... Because I did feel a dinosaur."

(Dawn, 47)

implying that she felt out of touch with contemporary practice and unable to justify her own practice if required. However, she clearly felt that training in SFBT had reversed these feelings, to the extent that she could now use her own practice as an exemplar to student nurses, as illustrated here:

"It [my previous mode of practice] was okay and yeah it was; I did do it in a solution approach, and I think it did encourage people to get well ... but because it didn't have evidence base behind it, it was a bit flimsy, it's the only way I can describe it. Whereas now, with doing the course I stand up for what I believe in now, and where I am with working

with people, and it's made me a lot more confident in that way. But I also did an education slot for a while with the student nurses, on solution focused; I did a training session for them at the hospital when they were at their community placements."

(Dawn, 57)

Several other themes were apparent, including Dawn's perception that the *epistemological base* of contemporary mental health nursing practice was becoming more congruent with that of SFBT, in that it appeared to place greater emphasis and value on the subjective experience of the patient as opposed to the objective understanding on the part of the therapist. She cited the emergence of models such as the Tidal Model (Barker, 2001), healthcare policies such as 'the 3 R's' – 'Rights, Relationships and Recovery' (Scottish Executive, 2006) and the use of WRAP, or Wellness Recovery Action Plans (Copeland, 2002), as evidence of this shift, adding that her paper work is now 'so solution focused it's scary'. Interestingly, Dawn was the only one of the three participants who responded to questions about the 'knowledge base of nursing' by discussing an epistemological or theoretical framework for her practice; the two other participants both related the question to their own experience i.e. that knowledge was gained through personal experience. This is discussed in more detail later.

However, some of the most interesting text related to Dawn's thoughts on *working in wards*. This was a key area of interest for me and my assumption was that working in a ward, or team, setting made it more difficult to practice in an SF manner. One of Dawn's opening remarks was that when one was working in a ward team setting, one must work as part of the team - "go with what the other people are doing". It was only later, when I was analysing the interview, that the question 'why?' occurred to me in relation to this. It was clear that 'working as part of a team' was a given, as far as Dawn was concerned, and given

that few (if any) of the ward staff were trained in SFBT, this would make working in this way difficult. In fact, Dawn spoke of facing some opposition to working in a SF approach, having 'heated discussion' with her mentor, who was 'very CBT minded', and eventually 'agreeing to disagree' on a number of issues (although she also described this as a supportive relationship). Dawn also spoke of her awareness of the role of Consultant Psychiatrists in a ward team, describing some Consultants as being 'resistive' to staff working in SFBT, and describing the Consultant she worked with (in positive terms) as being,

"quite easy-ozzy to let each nurse practice in their own way. He doesn't put restrictions on us or anything ..."

(Dawn, 61)

The implication, I take, from this is that, in Dawn's experience, some Consultant Psychiatrists do not 'let' nurses practice in their own way, and attempt to restrict what they do and / or prescribe the therapeutic interventions they deliver. This, again, would make it difficult for a nurse to establish SFBT (or any new practice that wasn't supported by the relevant Consultant Psychiatrist) in a ward setting.

However, Dawn went on to say that it was, indeed, possible to integrate SFBT into a ward setting. She spoke of the increasing congruence between SF thinking and the 'recovery focused' thinking that informed much of the contemporary paper work nurses were expected to engage in, in other words, SF thinking permeated contemporary practice and Dawn could use this to validate the SF care she planned for patients in her care. In addition she noted that when she was working in a ward setting there was, in fact, very little time to engage with patients. Much of her time was spent, she said,

'jockeying' for access to a computer in order to read, or write up patient's notes, to an extent where "patient care, one-to-one, things like that, kind of falls by the way side sometimes" (Dawn, 23); therefore, SFBT was a useful approach for her as it gave structure to her (often) brief interactions with patients, as indicated here:

"We still manage to fit one-to-ones in, even if it's a ten minute one-to-one, five minute one-to-one, you can still utilise some aspect of the solution approach. Even if you're on an ob and somebody's speaking to you; client's maybe in their room sleeping, somebody's speaking so you – You can always get it in there, it's just the language. It's just normal now to use that kind of language at work. At the minute it's difficult with the one-to-ones when you're maybe grabbing five, ten minutes when you're off and trying to see as many patients in your team as you can because in a five minute slot you can still ask somebody, "Where are you on the scales? What have you done today that's different?" There's always some question you can ask, even if it's just one."

(Dawn, 18)

These comments of Dawn's began, then, to challenge some of the presumptive thoughts I had developed about the relationship between working in a ward team setting and integrating SFBT into one's clinical practice.

7.5 Interpretation

Davey (2006) argues that hermeneutical encounter requires more than the recognition of closeness of outlook or perspective between oneself

and another; rather, it involves the occupation of the *in-between*, the space between the familiar and the strange.

“It is the generative space of the in-between, the space of the hermeneutical encounter, which discloses the reality of alternative possibilities not presently my own but which might yet become my own.”

(Davey, 2006. P. 15)

With this in mind, I shall now explore the outcome of my encounter with Dawn’s text. One of the biggest challenges in engaging with *the other* in Dawn’s text was the familiarity I had with what appeared on the surface of the narrative. As I have said above I have known Dawn for several years, she is an active and enthusiastic member of the SF community, and she has participated in all three stages of my research (Pilot Study, Stage I and Stage II); as such, the difficulty for me was to separate what Dawn was telling me from what I anticipated Dawn telling me. Repeated readings of the text, engaging in a reiterative process of ‘questioning the text’ and then ‘questioning the answers’ I arrived at, in order to determine if my speculative conclusions could withstand the scrutiny of further investigation, allowed me to move my understanding beyond what I knew of Dawn on the surface, and develop a deeper understanding of her as a person and as the author of this particular text in which she attempts to tell me something new, something useful.

The first thing I took from Dawn’s text can be contained in the statement, **“Nurses have to work as part of a team, but I can be a bit of a rebel.”** To an extent, this surprised me about Dawn as I was fully aware of her ‘rebel’ aspects; not that I would have used that

term, but I was aware that she was something of a non-conformist who appeared to enjoy 'doing things her own way'. She had described how she had experienced the repercussions of not conforming to expectations during her training; of being confined to the linen cupboard for talking to patients, and of being chastised for 'too much hilarity'. It therefore surprised me that Dawn felt that working as part of the team was so important. However, she clearly stated that this was an aspect of 'ward working': perhaps if one terms this 'team working' (as opposed to 'ward working') the importance of 'working as part of the team' should have been more obvious to me.

Dawn saw her role as fitting into the team structure; she described this most clearly, in relation to her previous experience as an autonomous practitioner, when she said:

When you're working in the community you're autonomous, you're lone working, you've got your own group of clients; whereas on the ward, although you're in a team, like a consultant's team, you're also in the bigger team, you're in the ward team.

(Dawn, 59)

So for example, if another team member who was designated a patient's named nurse prescribed a 'problem-solving' approach, Dawn believed she should respect that prescription and work with the patient in a problem-solving manner. However, she remained able to indulge her 'rebel streak' by introducing solution-focused activities under the guise of 'recovery-focused' activities, or by just slipping "some tiny wee bit of solution in there" when working in a problem-solving way. It was, perhaps, also this rebel streak in her that allowed Dawn to accept that other members of staff may not honour her recovery plans

when she prescribed a solution focused approach to care (Dawn, 17). This last part can also be seen to demonstrate Dawn's solution-focused thinking in action, in that she focuses her attention (and the attention of her narrative) on the two members of her team who are becoming interested in SF working, rather than trying to overcome the resistance of the third team member; this can be seen as Dawn focusing on 'what's working' and encouraging the team to do more of that, rather than trying to engage with 'what's not working'.

The second statement I take from Dawn's text is "**I value people contact – I want to understand people**". I do not think this requires a great deal of explanation, as it permeates most of what Dawn says in her narrative. Specifically, she states that she sees the individuals she works with as 'people' and not 'patients' or 'diagnosis', and that her motivation was to help them understand themselves better and for her to develop an understanding of them. This implies both a contextual / interactional understanding of mental health problems, that these problems arise out of life events and resolution depends on the understanding one brings to these experiences, and, arguably, a hermeneutic approach to Dawn's engagement with that other person (Davey's [2006] comment above could be as relevant here as it is in the context of Gadamer's work).

The third statement I would make (on behalf of Dawn) is "**I drifted into nursing – it allowed me to engage with people and try to help them understand themselves**". The significance of this statement lies not so much in the latter part; the hermeneutic qualities of engagement and understanding are referred to above and reflect Dawn's drive to enter into a dialogue with the other person and, through that dialogue generate a shared, new and therapeutic understanding. Rather, the significant aspect lies in the first part of the statement. Dawn did not intend to become a nurse; this pathway was

simply an expedient route for her to engage in the activity she was drawn to. Dawn describes being a Hospital Cadet (Dawn, 24), a path she followed because she “hadn’t a clue what I wanted to do when I left school” and she lived in the hospital grounds. This allowed her to experience a range of hospital-based activities, and it was the “people contact” that she enjoyed and therefore pursued (again, there is a pathway here of ‘doing more of what works’). It could be suggested here that this begins to offer some definition of Dawn’s relationship with ‘Nursing’; Nursing for Dawn is an activity, she wanted to *nurse* (verb), as opposed to *become a nurse* (noun). This can then provide some understanding of the ‘rebel bitty’ of her narrative, in that Dawn rejects those aspects of her profession that she perceives as Nursing (to borrow from the German tradition of capitalising nouns) while valuing her nursing interactions with patients.

This, then, links to the fourth statement, “**SFT provided me with a structure for doing this in a more formal way**”. This reflects Dawn’s assertion (and the analysis above) that she had been working in a SF-congruent manner prior to undertaking training in the approach and that the training provided her with a framework around which to structure her existing practice. However, at this point I must proceed with caution; Gadamer clearly states that every aspect of hermeneutic understanding must be congruent with every other aspect of that understanding, in arriving at an understanding one must always be searching the text for any point of contradiction to what is becoming understood.

“We remember here the hermeneutic rule that we must understand the whole in terms of the detail and the details in terms of the whole. ... The harmony of all the details with the whole is the criterion of correct understanding. The failure to achieve this harmony means that understanding has failed.”

(Gadamer, 1979. p. 258/259)

Although Dawn states repeatedly that her previous practice was essentially SF in nature, there is a comment in her first interview (see Appendix 5) which could be taken to contradict this. In this comments Dawns says,

"I remember when we'd finished the class and Meggy and I were having a talk; and both of us have got long service, and he says "I wish I'd known about this thirty years ago", and I said, "I wish I'd known about it twenty-five years ago", because at least then we'd have been doing something constructive with our clients all these years."

(Dawn, Comment 43.24)

This would seem to contradict Dawns assertion that her practice was SF orientated before she commenced her SF training; there is an obvious implication in this statement that she has not been doing "this" and has therefore not been as constructive (helpful, useful) to her clients as she would have been if she had been practising SFBT. However, the emphasis in interpreting Dawn's meaning here must lie in what "this" refers to; from the context of her conversation, the simplest explanation would be that "this" refers to SFBT. Dawn and her colleague, Meggy, had just finished the class and were discussing the merits of what they had been studying – SFBT. Their shared perception was that had they known about SFBT earlier in their career they would have been able to deliver a more helpful, or useful, form of therapy than they had. In light of this, it can be argued that Dawn recognises here that she was not practising SFBT prior to undertaking training in the approach, what she has gone on to say, in both

interviews, is that there were similarities between the way she used to work and the underlying principles of SFBT. While her outlook and intentions were similar to those of SFBT, her ability to transfer those intentions into practice was enhanced by the structure training in SFBT provided. This was explored in a dialogue during her second interview.

S: So it [applying for the SFBT course] was to bring you up to date and yet, when you did the course, you realised it gave a structure to what you were doing before?

D: Yeah.

S: Which means either it didn't bring you up to date, it just gave a name for that, or you were up to date to begin with.

D: I don't know the answer to that one. I don't know the answer to that one. I think it, I was up to date I suppose, but I didn't have the evidence based training of it.

S: Ahh. Right. Okay. So, you were up to date in your practice but you didn't have a title, didn't have a name for it. Sort of, 'just doing what I do.'?

D: Yeah.

S: Was it going to cut the mustard?

D: No.

S: Right, so why was it important to have a name for it?

D: Because I was feeling like a dinosaur with everybody else that was coming through, the younger folk coming through with their training and had more dynamic, and more evidence based names and titles and words if you like, where I was still talking year dot

S: Uh huh. And what was year dot about? What were you talking?

D: I was just listening to people more than anything, letting them tell their stories; now that's what I would call it but I didn't know that at the time."

(Dawn, 51-54)

It can be seen that this training also provided her with a name and an evidence base upon which to base her developing practice, which

informs the second-to-last statement I would make in relation to Dawn's text, **"SFT gave me a sense of professional credibility and it fitted with what I had previously been trying to do."** So, while SFBT fitted with Dawn's ontological outlook on life, she had not previously had a clear methodology for implementing this into her practice, rather she had tried to do what she thought was 'right' while worrying that what she was actually doing lacked credibility in an increasingly evidence-based world of practice. Having trained in SFBT Dawn was now able to discuss the underlying theories and principles to her practice in a way that not only provided her with a professionally credible framework, but she found that this framework *not only* fitted her ontological outlook but also fitted with the emerging epistemology of the 'recovery model' being promoted in contemporary Scottish mental health care. Hence the final statement: **"SFT fits with contemporary values-based practice, so it brings me in line with current thinking too."** I would thus encapsulate my interpretation of Dawn's text in the following six statements:

- Nurses have to work as part of a team, but I can be a bit of a rebel.
- I value people contact – I want to understand people.
- I drifted into nursing – it allowed me to engage with people and try to help them understand themselves.
- SFT provided me with a structure for doing this in a more formal way.
- SFT gave me a sense of professional credibility and it fitted with what I had previously been trying to do.
- SFT fits with contemporary values-based practice, so it brings me in line current thinking too.

7.6 Conclusion

I would argue that Dawn's experience of training in SFBT enabled her to link her ontology with her methodology and brings that in line with contemporary epistemology in mental health nursing. In addition, incorporating SFT into her practice allows her to be part of the team, while still being a bit of a rebel. Having said that, something must be said about (my interpretation of) Dawn's ontology, epistemology and methodology. I think the text makes it apparent that Dawn's ontological goal (in terms, at least, of her nursing practice) is to help people. However, she is not intent on pursuing an expert role in this; rather, she sees people as the experts in their own lives, and her role, then, is to engage with people in order to help them find the answers they need to continue 'making sense' of their lives, to develop an understanding. This would then assume that there is no specific 'best' way to live life, rather, we must all find a way of living that meets our own needs (and, by extension of our relationships with them, the needs of those around us). This goal is supported by an essential methodology of 'listening to people'. *Listening* in the sense of engaging people in a dialogue, enabling them to be heard (and to hear themselves) in the process of co-constructing a helpful understanding of the world around them. *People* in the sense that Dawn has made it clear that she looks upon the people she works with as 'people', not 'problems' or 'diagnosis bearers'.

This would appear to have been the basis of Dawn's way of working prior to undertaking training in SFBT; however, it was not something that she was confident in, in the sense of it being a legitimate therapeutic way of working. Training in SFBT provided Dawn with both a structure around which she could hang her preferred way of working,

and an evidence base to support her interactions. In terms of the epistemology guiding her practice, Dawn clearly believes her work is underpinned by contemporary Scottish healthcare policy, including the '3 R's', the Tidal Model and WRAP, and was able to discuss the relationship between these policies and practices and the SFBT approach to working with clients. In Dawn's eyes, there is then, a clear correlation between these ways of seeing people and their problems and the perspective taken by SFBT.

In conclusion then, training in SFBT provided Dawn with an epistemological framework to understand in a practical sense contemporary healthcare policy, and it thereby allowed her to link her own methodology and ontological outlook to contemporary nursing epistemology. An overview of the analysis of Dawn's text can be seen in Appendix 7.

Chapter 8: Interpretation of Texts (Stage II): Judy

8.1 Chapter Overview

In this chapter I shall provide an interpretation of the text of my interview with Judy; beginning with a review of my background relationship with Judy, I will then thematically analyse the text, using specific examples to illustrate and support the analysis. I will then provide my interpretation of the text, arguing for key points of understanding emerging from the interpretation, and concluding with a clear statement delineating my understanding of Judy's experience.

8.2 Judy: Background

Judy is a Staff Nurse, in her mid-twenties, who was about two years qualified at the time she undertook training in SFBT, and had worked exclusively in ward based settings during that time. She describes herself as coming from an extended family of healthcare professionals and, despite several members of her family advising against healthcare as a career choice, she was drawn from a young age towards nursing. She undertook health-related work experience at school and worked in a nursing home to gain experience and insight into nursing as a career option. By the time she left school she was clear that nursing was what she wanted to pursue as a career.

"I always wanted to, don't know, I guess again at school kind of age I was doing work experience and started working in a nursing home, again, getting experience for doing nursing and to see whether it was the right thing for me and really enjoyed it and I got just a, the whole, back kind of stage kind of more like the caring kind of sides and found it really quite satisfying in a sense, I guess."

(Judy, 31)

Having decided on a career in nursing, Judy was clear that it was mental health nursing that interested her, although she found it very difficult to express where this interest came from. She described being intrigued by the 'unknown' quality of mental health and mental illness, and the 'personal' quality of mental health problems. She perceived there was no right or wrong understanding in relation to mental illness, nobody had a definitive answer ("there was still a lot unknown or that nobody else can argue, so many different opinions or, and I liked that"), and individual experiences were open to interpretation ("I liked that even, it was more individual, kind of, illnesses were more individual, I think that was what I was kind of thinking, to the person whereas the general you've got a broken leg and this, this and this happens.").

I first met Judy when she commenced the SFBT course several years before we undertook her first interview. However, we never kept up contact after the course completed and, although our paths crossed occasionally, I had the impression that Judy had not found the course particularly useful. In light of that I was surprised and, I have to say, very impressed when Judy volunteered to participate in the research project (I have always had the impression that Judy saw participation as the responsible action of a professional practitioner; a position I greatly appreciated). When she commenced the SFBT training course Judy was working in a ward setting as part of a multi-disciplinary

team; however, since completion of the course Judy has moved into a Community Mental Health Team and is now working in a much more autonomous role. According to my prejudicial expectations Judy should now be finding it easier to apply SF practice to her client care and be more satisfied with the outcomes of her training experience than she was when she worked in a ward environment.

8.3 Analysis of Text

Like the previous interview, analysis of the text of Judy's interview revealed a number of emergent themes. The major theme to emerge from the interview was Judy's *reasons for becoming a Nurse*. This has been alluded to above and was clearly something Judy found difficult to verbalise. She was clear that she had wanted to be a nurse from a young age and that Mental Health Nursing was the only branch of Nursing in which she was interested; however, why this should be the case she found difficult to explain. She stated that she was always interested in aspects of mental health and was reading books on the subject while she was at school. Initially, at the time of the interview, I had understood Judy to mean that she had been reading novels set in a mental health context; however, on later reflection I recognised that she may also have been referring to text-books on mental health. This, in turn, led me to ask why she had been reading text-books on psychiatry while at school. The answer, which Judy had volunteered during the interview, was clearly that she "wanted to know more" about the subject; an obvious response, but one that added little to my understanding. In paying closer attention to the text and the context in which utterances are made I noted that Judy "didn't understand" mental health issues as a youngster,

"I guess I did just find it really intriguing, and remember back at school just reading books and Mum thinking, "What on earth are you doing?"; yeah. I just found the whole thing quite fascinating really and at that age I didn't understand, or know enough about it, and just always wanted to know more."

(Judy, 33)

There is a sense here of Judy having a need to know about these issues, of having to *know enough*, and trying to access this information through her own reading. She appeared to be attracted to a view of mental health problems that perceived these as idiosyncratic, or personal traits, rather than disease entities, and held the view that there are no 'right answers' in psychiatry; this began to suggest to me that Judy may have had experience, within her family, of mental health problems and that she may have been a carer for someone as a youngster.

One point in Judy's text especially struck me; she states that she does, in fact, know why she was interested in mental health from a young age, but was unable to express that reason at that time. In response to the question 'what was it that was attractive about healthcare?' Judy attempted to answer, but eventually attempted to cut off the line of enquiry.

"But it was just, that was ... emm, I don't know exactly why. Sorry, well; I kind of do, but I can't find the right words to explain, emm ... I always wanted to ... don't know."

(Judy, 30)

In reading this I was reminded of my own experience being interviewed, which was alluded to in the previous chapter. In reflecting on that interview I noted that 'I only shared what I wanted to share'; although the interview was conducted in a warm and safe environment in which I trusted my interviewer to maintain the confidentiality of our conversation, there were some questions that I could see would lead to areas I did not want to discuss, and therefore avoided. This reflection brought me back, afresh, to the guidelines I had established to guide my engagement with these texts (see previous chapter), and in particular the guidance to 'Listen to what she is telling me through the text (recognise that she is being the best narrator that she can be – what does she need from me to help make her meaning clear?)' and 'Stay text-focused – avoid 'red herrings' (Intuitive interpretation must be based on the text)'. In relation to the latter guideline I realised that I was now attempting to interpret *what had not been said*, at the expense of what had been said, and in respect of the former guideline I recognised that I owed a debt of honour to Judy to hear *everything* that she was telling me; that she was telling me that she had always wanted to be a mental healthcare worker *and* that she was unable to tell me why.

This realisation led to recognition of the second theme to emerge, which was that Judy found it *difficult to verbalise her thoughts*. Again, there appeared to be clear evidence of this; Judy would frequently begin a statement and then, either attempt to qualify what she had just said or (appear to) assume a shared understanding that did not require verbalising. In response to a question on how she would describe her style of working, Judy replied,

"Well, I guess taking all aspects and reflecting on previous practice. Because my experience before was from the ward and now in the community and seeing, again, how others work as well and just

incorporating it all. I guess I'm still, kind of, learning and readjusting how I do things. It's all experience and learning so I'm not sure if I've got a set, completely way of working as yet. It is still, I am still, kind of, reflecting and modifying you would say but it certainly has aspects of the course still there like I said, it's like if you're in the ward you do kind of take away a lot of that with it."

(Judy, 14)

There is a sense here that Judy is attempting to discuss around, and validate, an answer which she has in mind, but that she hasn't necessarily spoken out loud. An alternative perspective might consider what Gadamer (2009) has referred to as 'language games'. Wittgenstein (2009), more famously, utilised the same term to describe the interactive way that words are used in a social manner to convey meaning; this is a fundamental assumption of SF practice, and as such, has informed my prejudicial thinking in interpreting Judy's text. Gadamer has described language-games as where we "rise to the understanding of the world" (p. 446) and it could be argued here that, in keeping with the 'rules of the game', Judy has answered the question without imparting any detailed information.

Again, I speculated as to why this might be the case; Judy is able to describe clearly the tasks she undertakes in performing her role, but becomes less clear when discussing more abstract aspects of what she does. Perhaps the most obvious conclusion to draw may be that she has less of an understanding, herself, of the more abstract aspects of her role; drawing this conclusion would not, however, be to interpret Judy's text as 'the best audience' would. This is unlikely to be the meaning that Judy is intending to convey. It could be argued that Judy does not practice SFBT in her role and, although she finds this professionally appropriate, she may find it socially embarrassing to acknowledge it openly and, therefore, avoids the issue. While this is a

more respectful interpretation in terms of Judy's professional awareness (and, as I stated above, Judy's professionalism struck me throughout the interviews), it is still an interpretation of what was *not said*. In fairness to the text, all I can take from my interpretation is that Judy found it difficult to express her ideas verbally. Why this should be so was not discussed in the interview (in defence of this, I wasn't consciously aware of the fact until after the interview was completed).

The third theme to emerge from the text was that Nurses *work as part of a team*. Judy described her role in relation to being part of a wider multi-disciplinary team in which team members worked together to best meet the needs of the individual patient. She described this as a flexible, collegial style of interaction in which team members would assess a patient and then may refer on to another team member as appropriate, as described here:

"The referrals would go to whatever practitioner for assessment, [so] as to gain what was required; so I might assess somebody and feel that it's then ... because often a referral doesn't give a comprehensive, you know ... so I might then go and see them, and realise that I'm not the best suited person to see this person and then give to one of my colleagues, or not continue to see the patient; depending on what's required."

(Judy, 20)

However, she also referred to, what appeared to be, implicit rules with regard to how the teams operate. Teams were Consultant led and, although Judy initially described the decision making process as a collective process where decisions were reached by consensus, it became apparent that decisions reached were implicitly ratified by the

Consultant team leader. This appeared though to be a feature of team working that Judy wasn't entirely comfortable with. In describing the process for allocating a team member to work with a newly referred patient she stated,

"There's a team meeting once a week. All the referrals are discussed and again the ward patients are discussed again and allocated to who's most appropriate to be seeing with. [Steve: Right. And how does that process, sort of, arrive at that; the 'who's most appropriate?'] I guess, through discussion, but ultimately the Consultant's opinion; but I mean all kind of disciplines are at the meeting, from Psychiatrists ... well Consultant, to Speciality Doctors, to Social Work, to CPN, to Psychology are all present at the meeting, so it would be discussed and sometimes just naturally falls to, you know you, so you can have experience ... you know ... who would be best appropriate, but ultimately it would be the Consultant's decision. If there was, you know, a discrepancy as to who ... "

(Judy, 6)

This description, to me, eloquently describes the interactions of the multi-disciplinary team; a team of equal colleagues in which the Consultant Psychiatrist is implicitly perceived as first-amongst-equals with the deciding vote on all decisions. Several minor themes were also linked to this theme of *working as part of a team*; these included the focus of the team on CBT-style approaches to therapeutic working, and the associated difficulty of incorporating SFBT into a team approach (where CBT was the dominant approach), and seeing the patient as an individual. This last minor-theme (which was inherent in much of what Judy said, while rarely being made explicit) relates more to Judy's desire to give her patients a choice of treatment interventions to suit their diagnosis than it does to conceiving of her patients as individuals with their own personal world view; in other

words, the patient's individuality extends to their choice of treatment, but not their choice of world view. Judy describes her ideal self as,

"It's depending. Every circumstance is different but as to being able to, yeah, do the best that I could with each individual, being, you know; listening to them, to empathise with them, to be caring and to be able to provide them with the best that I can. Kind of meaning that I can't always be the answer, but then if, you know, it means a colleague or somebody else or some ... but for me to provide them with, yeah, the best resources that I have and to treat everybody as an individual. I guess I'm thinking more community rather than ward but...sorry, it's still quite general. (laughs)"

(Judy, 51)

What seems essential to this text is that Judy believes that patients benefit from being *seen* as individuals (as opposed to necessarily being *treated* as individuals), which is an ontological position rather than a methodological position; the patient, who is an individual person (with a mental illness), is offered a choice from a menu of available resources.

8.4 Interpretation

In interpreting Judy's text I have arrived at a series of interconnected statements, which I have grouped together in related clusters. The first of these relate to Judy's relationship with SFBT, and by extension, arguably with me. It seemed to me that Judy was at pains to avoid saying that she had not found SFBT useful to her practice. This is understandable as I am clearly an exponent of SFBT and Judy may

have felt that it was confrontational (or simply impolite) to tell me she had not found it useful in practice; indeed, the potential for respondent-bias in this research, in terms of only those who are 'pro-SFBT' volunteering to participate, was recognised from the outset. It was therefore all the more commendable that Judy, who has always struck me as a polite and non-confrontational (but not avoidant) professional, volunteered to participate in the study. However, Judy had clearly not found the SFBT training experience as useful as she might have hoped, and this can be encapsulated in the following statements I have made, based on my interpretation of what I believe Judy (the best author she could be) was trying to communicate to me (the best audience I can be):

SFBT is a good approach if you work that way, but I do not work that way.

My way of working is directed by the context of my team.

These statements, I believe, convey the meaning that Judy did not wish to disparage SFBT as a therapeutic approach; however, it was not an approach she used as she worked as part of a wider team. Judy then went on to speak more about the nature of that team work.

Nurses work as part of a greater team.

Most of our work is involved in assessment.

These statements convey the sense that Judy saw not only her own role as being part of a wider team, she saw the role of the Nurse as being inherently part of a wider team. According to Judy's view,

Nursing is part of an integrated health care package, which involves Doctors, Psychologists, Social Workers and (presumably) other Allied Health Professionals. The role of the multi-disciplinary healthcare team is essentially to assess the patient's condition and then provide an appropriate resource to either treat the condition or support the person with the condition. Judy clearly saw *assessment* as a major part of her role; it is interesting to note that while she often found it difficult to articulate the more abstract aspects of her role, she gave a very coherent account of the assessment process.

"Throughout the whole, kind of, adult CPN now; from every kind of level, kind of practitioner ... say like myself or a psychiatrist ... there is a kind of guidelines of, I think it's like thirteen points that you have to address and complete. As I say; from current presentation to medication to mental state and ... I can't remember them all off my head now. But no, it's the social circumstances, drug/alcohol use, suicide, abuse of any form, these all have to be documented and are part of your assessment."

(Judy, 22)

This not only suggests the key aspect that *assessment* takes in the nurse's role (although Judy states that any member of the team *could* carry out this assessment, it is implicit in her text that this is usually carried out by the nurse – the CPN), but also the nature of that assessment. This is clearly a base-line assessment of need, as opposed to a problem-based therapeutic assessment as utilised in therapeutic approaches such as CBT, or a solution-based assessment as found in SFBT. The nurse's role here, then, would appear to be a conveyer of information; conveying assessment data to the team and conveying resource information to the patient. Indeed, Judy noted that there were "a set of requirements" (Judy, 21) that described what information was required by the team before an assessment could be

considered complete, and that her goal was to provide patient's with the best resources she had available in order that they might be able "to get on with their life and have a better quality of life" (Judy, 54). The team that Judy describes would appear to be an integrated, cohesive unit in which team members gather information using their specialist professional knowledge (e.g. Social Workers, Psychologists, Psychiatric Trainees and Mental Health Nurses utilise knowledge from their own respective fields) and report back to the Consultant Psychiatrist acting as Team Leader, whereupon an intervention is agreed utilising the skills of the 'most appropriate' team member; leading to a further round of assessment and (if necessary) intervention.

The next set of statements I would make based on Judy's text are:

Becoming a nurse was always an ambition.

I can't say why I wanted to become a nurse.

I want to help people as individuals.

This, for me, was possibly the most ambiguous part of Judy's text. Had I been following Schleiermacher and Dilthey in attempting to understand *the author* of the text, and the process by which these thoughts came to be expressed, I would have been in a very difficult situation. There is certainly a lack of narrative integration in what Judy says, the importance of emplotment in narrative structure is made clear by its absence here (Polkinghorne, 1995); the means by which 'A' gets to 'C' is obscured, by the missing 'B', in the narrative progression. It is, of course, her inalienable right to retain, as private, information she does not wish to share, and, it follows, that I have a

duty to preserve the privacy of that information by not 'interrogating the data' unduly (despite its contemporary usage in certain organisational contexts as a synonym for analysis, this is not a term I use often; however, I think it delivers the aggressive and intrusive nature of the activity that I wish to convey).

However, for Gadamer, departing as he does from the tradition of Schleiermacher and Dilthey, what is important is what the text says to me; that I engage in a genuine encounter with the *truth* of what was said. The first part of what Judy told me is clear enough; Judy grew up in a family with a number of other health care professionals in the extended family and, from a young age, she wanted to be a Nurse. Strangely (perhaps), this was not the traditional, stereotypical narrative of a little girl, dressed-up in her red-crossed bodice, cape and cap wanting to be a Nurse when she grew up; Judy wanted to be a Mental Health Nurse when she grew up. Adult Nursing (the potentially misleading term relating to what was a Registered General Nurse prior to 2002) was not a role Judy aspired to, she saw that role as overly prescriptive and restrictive in how one interacted with patients.

"General; you've got a broken leg and this, this and this happens. Or that wasn't ... the very general, I think, kind of, opinion that I had then or...I didn't really give General Nursing a huge amount of thought to be honest because it was kind of dismissed quite early on. I guess my opinion then was, the kind of the ward environment and the more kind of care of physical problems and how it was more regimented as to 'They have this disease - this is the treatment'. And that's what you do, whereas with mental health it was like, well, that kind of diagnosis and treatment was a lot more expansive (laughs), you know?"

(Judy, 36)

In a sense, this is surprising, in that the role Judy describes for her current practice does sound rather regimented; however, it can be assumed that Judy does not find it so. Mental Health Nursing was the direction Judy wished to pursue, apparently to make a difference in the world of mental health care; however, she was unable to find the words to express this further, beyond a clear message that she wanted to work with people as individuals. This would appear to be at the core of Judy's practice; that patients are seen as distinct and discrete individuals. Understanding this statement took me some time, in that much of what Judy actually described to me struck me as rather generic in its approach. Working within a medically-led model of care, patients are seen within a diagnostic framework and are provided with treatment interventions from a finite pool of resources, this struck me as being slightly at odds with Judy's aspiration to provide individualistic care.

However, having spent some considerable time engaging with the text, I have come to understand Judy's position as one where the unique individuality of the person is at the core of her engagement with the person. Patient's may have collective diagnostic categories and collective treatment options, but they are always individual people with lives and families and existence; a more profound understanding than that which I brought to the interview. This understanding is, then, linked to the final set of statements.

I would like to have greater knowledge and structure to what I do.

SFBT did not give me this.

CBT has clearly provided this to other Nurses, and will hopefully benefit me.

At the time of the second interview Judy was still a relatively young practitioner, developing her craft (if I might use that term). I have made reference to, what I perceived as, her professionalism in participating in the research, and this impression, of an aspiring practitioner, is embedded in the first statement above. Judy recognised that qualifying as a Mental Health Nurse was only the first step on her journey and she was in the process of developing her skills and expertise further. She spoke of her experience working as part of a ward-based team as an “invaluable experience” and “a good foundation” for her current practice,

“I think that mental health nurses should have experience of that, and is certainly, as a CPN I often go back to that experience and it has helped how I practice now.”

(Judy, 42)

Nevertheless, she recognised that further training was required in order for her to achieve her potential as a practitioner. Specifically, Judy recognised that she needed greater knowledge relating to specific psychological therapies and a structure around which to apply that therapy. In discussing a colleague who was trained in CBT, Judy commented that she aspired to having the level of skill and expertise her colleague demonstrated.

“My impression is that she has a lot more knowledge skills, experience working with CBT and is able to do a lot more complex kinds of cases than myself. I think she would work in a more structured way because she has all that kind of knowledge training behind her and I don’t and I guess I would

like to work in that kind of, would like to know more to..."

(Judy, 47)

This may reflect my comment above, that there appeared to be a disparity between Judy's early ambition of working in an un-regimented, client-led manner, and her description of her current role (which I saw) as essentially carrying information between team and patient. Judy explicitly aims to work with people with complex problems and to do so in a structured and informed manner. In order to achieve this she was about to undertake the same training programme in CBT that her colleague had completed.

Judy stated that she had undertaken the SFBT training course in order to achieve a level of knowledge and structure to enable her to practice in more complex casework; she had been unable to realise that goal largely because she had been unable to practice SFBT in either of the settings in which she had worked since, and therefore had been unable to convert the knowledge she had gained into practical use.

"Again, more psychological, best way of working, kind of approach, more structure to what I was doing and how to provide that for the patients as well, knowledge, experience and confidence as well to be able to provide that."

(Judy, 50)

The important aspect of this for Judy was being able to put what she had learned into practise. In her first interview, during the Stage I interviews, Judy acknowledged that she had been disappointed that she had been unable to practise SFBT after completing the course and, in light of that, she had made a distinction between her experience of the training course itself, which she scaled at 7, and her experience of taking SFBT back into practice, which she scaled at 5. Her training in SFBT had, therefore, failed to provide her with the specific knowledge and structure to practise in the manner she aspired to, and so she had now applied to undertake training in CBT. She understandably believed that her potential to achieve her goal was enhanced by undertaking training in this modality; there were several reasons for this. Firstly, she recognised that CBT was the model supported by the team in which she worked (Judy, 12); there was another practitioner trained in CBT within the team and the team was keen to have a further clinician trained in this approach.

Secondly, and supporting the previous factor, she recognised that there was demand for this type of therapy,

“... a lot of the referrals are requesting CBT because that’s what they think that the patient needs. It’s not always the case but it’s, kind of, the buzz word and they put in in their referrals, ‘Could possibly require CBT’ or a ‘CBT approach would be beneficial for this patient’.”

(Judy, 10)

Clearly she was unlikely to repeat her experience of SFBT and come back with a skill set she would be unable to incorporate into practice.

Finally, the training course in CBT was fully funded by her employers (Judy, 13); this not only implied that the training was supported by her organisation (although the training in SFBT had also been fully funded by the same organisation), but it was a *de facto* requirement for Judy to consider the training programme in the first place. Like the other practitioners interviewed in Stage II, Judy considered full funding from her employers a prerequisite before she would consider applying for a training opportunity (this is, of course, not particular to these three practitioners and reflects the widespread, and international, perception of nurses as 'employees' and the responsibility for professional development lying with the 'employer'; see Lawton and Wimpenny [2003] and Hegney et al [2010]). Taking these three factors together, Judy had seen that training in CBT had been of benefit to other nurses and therefore, was likely to be of benefit to her in her professional development. I would therefore encapsulate my interpretation of Judy's text in the following statements.

- SFBT is a good approach if you work that way, but I do not work that way.
- My way of working is directed by the context of my team.
- Nurses work as part of a greater team.
- Most of our work is involved in assessment.
- Becoming a nurse was always an ambition.
- I can't say why I wanted to become a nurse.
- I want to help people as individuals.
- I would like to have greater knowledge and structure to what I do.

- SFBT did not give me this.
- CBT has clearly provided this to other Nurses, and will hopefully benefit me.

I would further argue that Judy is seeking a methodology that fits with her ontological standpoint and, that while she is reluctant to dismiss the approach completely, SFBT did not give her that fit. In keeping with the above, I would suggest that Judy's ontological standpoint is described by a desire to treat people as individuals. She wishes to listen to people, empathise with them and care for individual patients at a personal level; to have a genuine human engagement while delivering evidence-based care. Judy, I believe, perceives this as the responsible role of a proficient and professional nurse. The methodology that she brings to this can be described as being a part of a multi-disciplinary team; central to Judy's understanding of nursing practice is the role of the nurse embedded in the structure of a unified team. She seeks to have a structure to how she does this; knowledge, experience and confidence to deliver care reflecting good nursing practice. Interestingly, Judy spoke very little about an epistemological base to her practice. She was clear that 'nursing knowledge' enabled one to practise nursing well; however, this knowledge was gained from practice and experience possibly reflecting a pragmatic and practical, as opposed to theoretical, conceptualisation of nursing practice.

8.5 Conclusion

In conclusion, then, training in SFBT did not provide Judy with a practice that fitted with her current methodology of nursing; she did not have the opportunity to convert the empirical knowledge she

obtained on the course into experiential knowledge, which currently drives the epistemological basis of her practice. In short, for Judy, SFBT isn't what nurses do, and therefore it added very little to her practice as a nurse.

Chapter 9: Interpretation of Texts (Stage II): Lesley

9.1 Chapter Overview

In this chapter I shall provide an interpretation of the text of my interview with Lesley; beginning with a review of my background relationship with Lesley, I will then thematically analyse the text, using specific examples to illustrate and support the analysis. I will then provide my interpretation of the text, arguing for key points of understanding emerging from the interpretation, and concluding with a clear statement delineating my understanding of Lesley's experience.

9.2 Lesley: Background

Lesley is an experienced nurse in her early thirties, with a range of experience of ward-based nursing and, more recently community-based nursing. Although her father had some limited experience working in a hospital for people with learning disabilities, she did not come from a family with a strong tradition in healthcare. Still, she grew up in the vicinity of a large institutional hospital and, at the time of leaving school, she had no clear idea of what she wanted to do.

"I was at school and I wasn't doing very well at school and (laughs) they asked if I could, sort of, get ... well they basically said if I could get a job then I could leave; so I think they wanted rid of me.

So, I just sort of frantically thought, hmm, 'what could I do for a job?'"

(Lesley, 45)

Like the other participants in Stage II, Lesley had had some experience of working in a hospital, as a volunteer helper, from her work experience at school and based on this experience she applied, first, for an ancillary role in the hospital and then applied to train as a Nurse. From her first contacts with patients in the hospital she was interested in them as people and wanted to know more about them at an interpersonal level; it was this interest that drew her into nursing.

"I just wondered what was wrong with them or why they were like that or, you know, how they lived and just really nosey".

(Lesley, 56)

I first met Lesley when she commenced the SFBT training course. She kept in touch with me after she completed the course and we would meet up at SF events and meetings. By the time of the Stage II interviews I would say that I had a good relationship with Lesley and she was clearly part of the community of practitioners who promoted SFBT in the practice. When she commenced the SFBT training course she was working as a Staff Nurse in a ward-based setting; however, by the time of the second interviews she was working in an autonomous community-based role. According to my prejudicial expectations, then, I would have anticipated that Lesley had been largely unsatisfied with her earlier experience but had now become more satisfied with her use of SFBT in her current autonomous role.

9.3 Analysis of Text

Like the previous interviews, analysis of the text of Lesley's interview revealed a number of emergent themes. The major theme to emerge from the interview was the importance of *Communication* for Lesley. This appeared to be the motivation for her becoming a nurse and the driving force in maintaining her interest in her career. From the time of her experience as a volunteer helper, when she was at school, Lesley had found the communication aspects of talking to, and interacting with, the patients in the hospital to be the area that drew her interest. Her experience gave her the opportunity to observe what Nurses actually did, in the context of communication and social care (as a volunteer she would not have been present when physical personal care was being carried out),

"and I just really enjoyed it, really liked it and really, obviously you weren't really getting involved, you were just a volunteer so you would sit and speak to the patients and things or play games or take them out for a walk and things like that and I just really wanted to know more about them, why they were there, what was wrong with them, what it meant and I just found it really really interesting and I used to watch the nurses with them and think 'Oh, I'd like to do that' or 'That's really interesting, I'd like to be able to do that.'"

(Lesley, 47)

Lesley admitted that she was probably unaware of the distinction between Learning Disability Nursing and Mental Health Nursing when she applied for her training (Lesley, 50); there is a sense in her narrative that this wasn't an important factor for her at this time, she was clearly good at communicating with people and a career in nursing

would both give her an opportunity to use those skills and satisfy her need to find work.

"I think it must have been my Mum who said, 'Oh, you're quite good with old folk', or 'You're quite good with speaking to folk, why don't you go and be a Nurse?' or something. So I think she maybe suggested it, she probably did, and I thought, 'Ach, okay.'"

(Lesley, 52)

Lesley therefore drifted into nursing with no clear aim of what she wanted to do beyond 'understanding' the patients she had met; who they were and what their lived experience was. Having discovered that she was training to be a Mental Health Nurse, Lesley found the opportunities for communication even greater than she had anticipated and she developed an interest in understanding the conditions and disorders that typified mental health problems; again, there is a sense from the text that, rather than an academic or technical interest in the basis of mental health problems, it was the impact of these conditions on the individual that Lesley wanted to understand.

"I found it more interesting I would say, once we started doing the mental health stuff; I thought, 'Oh no, this is even better. This is what I want to do.' And I, yeah, I found that even better than the learning disabilities. I just found it more interesting, once we started speaking about the disorders and that sort of thing and the communication and all that kind of, I just found that really fascinating and really enjoyed it."

(Lesley, 63)

This interest in communication informed much of the second theme to emerge from Lesley's text; this was related to her *Previous Training*. Unlike the other two participants, Lesley had undertaken considerable training prior to commencing the SFBT course. Not surprisingly, perhaps, much of this post qualifying training was related to psychotherapeutic interactions, what would be broadly termed (with some obvious exceptions) as 'talking therapies'. The first of these training experiences was shortly after she qualified as a Mental Health Nurse, and was in Person-Centred Counselling (PCC). She did not enjoy this experience; she appeared to be interested in learning about PCC, but was then disappointed in what she learned, in that it did not fit with her ontology.

"I remember being told that two Lesley's turned up for the class and one of them; she was really interested and if there was something you were really interested in, you really knew because I would have sat forward and I would listen, and blah blah blah, and the other Lesley just sat with her arms folded and was, turned up her nose and I remember being like that, I remember thinking, 'Oh, do we have to go through this again?'"

(Lesley, 68)

It would appear that Lesley's initial enthusiasm was tempered by the interpretive aspects of PCC; the shift from surface-level communication of what the patient's lived experience is to a deeper analysis of the communication and what it reveals about the patient's unspoken self. It may be, as Lesley herself suggested (Lesley, 67) that she was too young and emotionally immature to engage with the implications of PCC; however, there is a strong suggestion in the text that the 'therapist as expert' role was something that Lesley was uncomfortable with.

"I remember we went to the pub [after a training session] and I brought my folder and I'd sat it on the table and I remember it was picked up upon, 'Oh that's interesting that you brought your folder and sat it on the table when we're out for a social occasion'... I just thought, 'Oh, for Christ's sake.' I remember there was a lot of that sort of stuff, like observing you and noticing things and I just kind of, couldn't be bothered with that, I just thought, 'Oh, please' but you know, now I would have probably just found that funny or, you know, interesting, whereas at that time I took it as a personal insult."

(Lesley, 70)

Although Lesley's youth at the time may account for why she took such experiences as 'a personal insult', it is clear from the text that she retains a sceptical position in relation to this form of interpretive communication (Lesley does later state that, as a more mature practitioner, she may 'sometimes' now see merit in a PCC interpretation [Lesley, 71]; however, she does not provide any indication of the context such an event would involve).

Later in her career Lesley undertook a training course in Cognitive Behaviour Therapy (CBT); she was encouraged to undertake this training by a colleague on a specialist unit she was working in at the time. Again, Lesley appeared highly motivated to undertake this training, in that it was a requirement to have this training (or some other form of 'talking therapy') in order to work in a specialist sexual offenders unit; however, once again Lesley did not enjoy the training experience. In this instance, while she appears to have been comfortable with the underlying principles of CBT, she felt unsupported in applying those principles in practice as a learner (Lesley, 76). She described working with clients who had multiple and complex

problems, and finding the process of exploring the dysfunctional thinking surrounding these problems to be very challenging.

“One of the guys that I was seeing had post-traumatic stress disorder and he got worse when I was seeing him and I just found it really difficult to cope with; I just really felt that I was making this guy worse and anyway, turns out he had loads of different problems and he ended up being a hustler for going into pool halls and all this sort of stuff came out, criminal activity and things like that it was just so hard. You know, as a student I was just learning how to do this therapy and all this stuff was coming out from this guy and I was going to supervision and like ‘Oh, my goodness’ and ‘Whoa, why did I have to have this, could I not have had anxiety?’ Everybody else seemed to have more simpler cases.”

(Lesley, 75)

During this time Lesley also undertook a training course in British Sign Language (BSL), a specialist form of communication for people with impaired hearing. Despite finding this new form of communication very difficult to master in the first instance (Lesley, 78), Lesley went on to learn (largely) from the patients she was working with how to communicate in this way. I suspect that this illuminates the various training experiences Lesley experienced; for her, training in (and the practice of) ‘talking therapies’ relates less to the technical ability to understand the ‘patient’s problems’ than it does to the communication skills required to understand the ‘patient as a person’.

“When I went in to that job, I’d say the first day in that job was possibly the worst day of my working life because I couldn’t communicate with anybody”

(Lesley, 78)

This highlights a third theme to emerge from Lesley's text, which is *Making a Difference*. This theme emerges, particularly, in her experience of practising in SFBT; however, the prominence she gives to her experience of making a difference suggests that this is an important goal for her. She speaks (Lesley, 18) about 'making a difference' to the care people experienced on an acute admission ward and, like Dawn, argues that SFBT can be a useful tool in a ward setting, where time for patient interactions is limited.

"You can make a difference to people you can make them feel sort of good about themselves, you can, you know, find people's strengths"

(Lesley, 20)

This may give an indication of 'the difference that makes a difference' (Bateson, 1972) in Lesley's experience; for her, 'making a difference' may be more about helping people 'feel good' about themselves, as opposed to 'understanding their problems' *per se*. Lesley expresses this clearly in one of the few complete narratives (in terms of a temporally emplotted story with a beginning, middle and end) offered by participants in the study, in which she describes spending an hour with a patient who was being 'specialied' (a form of close observation).

"I do remember a sort of specific incident, I do remember, you know you've got to do close observations a lot on the ward and I do remember a lot of time doing close observations, people would sit outside the room and maybe read a magazine and the person would be in the room, so I do remember after the course thinking this is actually a really good opportunity to get in and practice my solution focused therapy. There was a girl who was

about, I think the report that you got was she'd been playing up all morning or something like that, you know, manipulative behaviour or something like that. She was sitting there, sort of, in tears as I went in and they just kind of said, 'Oh, you know, she's been like that most of the morning' and blah blah. So I thought, here's a good opportunity to go in and I'd never met the girl before and they didn't know much about her that was kind of all you got told, 'Watch her she's a self-harmer' or whatever. So, I remember going in and really feeling after that hour that I'd, you know, it'd made a difference to this girl. Because we spoke about, you know, just sort of different things and, sort of, where she wanted to be and, you know, how she was going to get there and things like that and finding out a lot about, you know, a lot of sort of positive things about her and, you know, how she'd, sort of, I think she was a lawyer or something and, you know, just her strengths and things like that and I remember going away after the hour. And she was smiling, 'Oh, nice to meet you.' And you know, and I'm thinking 'Wow.' That was really, I really felt that I'd done something that hour and I do remember, I don't have a great memory but I do remember specific incidents like that, you know, using solution focused therapy of going in with that approach and coming out and just feeling like you'd made a difference to that person's hour whereas it could have been that you sat outside and didn't make any in roads."

(Lesley, 15)

It can be seen from this narrative that Lesley wanted to do more than simply keep the young woman safe (the *raison d'être* of special observations), she wanted to (and did) engage her in a therapeutic conversation allowing her to change from a position of tearfulness to one of social competence and containment. Being able to do this appears to be one of the reasons that Lesley maintained an enthusiasm for SF practice, although there is a clear indication that her desire to 'make a difference' predated her experience of SFBT (Lesley, 23); this links all of the above themes with a fourth theme relating to Lesley's *Ontology*.

As discussed above, Lesley approached her previous training experiences with both enthusiasm and an unarticulated requirement that the training should fit with her desire to communicate with people in order to better understand their experience; interpretive, 'expert' positions did not sit comfortably with her (Lesley, 71). Her ontological position was one in which exploring the positive was valued more than exploring the negative, and building the future was preferred to deconstructing the past (Lesley, 93). Speaking of herself, Lesley described herself as a 'people person' and a 'communicator' (Lesley, 103); someone for whom 'understanding the person' is more important than 'understanding their problem'.

"It's communication that I really buzz off and I think that is because I care and I like people and I like being around people and I like learning from people and people learning from me."

(Lesley, 105)

It's clear from this last extract that, for Lesley, learning is a circular process in which understanding is communicated back-and-forth between therapist and client resulting in mutual learning. This ontological position is, of course, entirely congruent with the position proffered by SFBT (although it is not exclusive to SFBT; Patrick Casement [1985] outlined a similar ontological perspective from a psychoanalytic modality).

9.4 Interpretation

Like the previous two texts being analysed, engaging with this text was not without challenges. In this case, and similar to the challenges encountered with Dawn's text, the issue for me was to engage with *the other* in a textual narrative delivered by someone I knew well; there was little in Lesley's narrative that I had not heard her say many times previously (I refer here to the *spirit* of what she says as opposed to the specific *content*; like all conversations, our interviews were unique events). How then to engage with *the other* in something I appeared to know so well? The process I adopted was, first of all, to acknowledge that my sense of 'knowing it so well' was an illusion, based on superficial understandings gained from casual conversations; in this, I would argue, I not only acknowledged my prejudicial understanding but also acknowledged the inadequacy of that understanding (this is also congruent with the process of 'not knowing' inherent in SF working). I then immersed myself in the text, looking for the new and the unexpected, questioning the text and, again, questioning the answers I gave myself; engaging with the text to uncover what it was that Lesley would want me to know.

As with Dawn and Judy's texts, I have generated a series of statements based upon my interpretation of Lesley's text. These statements reflect my understanding of what Lesley told me in the interview and, once again, I have grouped the statements into related clusters.

SFT gave me the skills to communicate more effectively with people.

SFT enabled me to make a difference in people's lives.

I did not feel valued in a team setting – I can make a difference in my current role.

The first of these statements relates to Lesley's ability to communicate effectively with the people she worked with. Lesley had arrived at a place in her career where she was feeling jaded and unmotivated (Lesley, 89) and was clearly looking for a change of direction (Lesley, 86), although she had no clear idea of what that change might involve, or where it might take her (Lesley, 85). However, having applied, on chance, for the SFBT training course she found that she was able to communicate with people at a level she had been unable to achieve before.

"I just felt more motivated after the course and felt there was more that we could do to help people. We could be more positive, we could be more, there was different ways of approaching a problem and there was different ways of responding to people, there was different ways of asking questions and, you know, the experience of that being positive made me feel, 'Oh, right. That's good. There's more that we can do and there's more that I can do as their nurse to help them or to help them see things in a different way.'"

(Lesley, 92)

It was this ability to help clients see things in a 'different way' that Lesley felt 'made a difference'. By focusing on what was working well in client's lives and focusing on their strengths and abilities Lesley was able to help clients make changes that she had not previously seen happen. I was reminded here of Norma's comment in Stage I of the research, "surely I've got to be able to do more than just be with people when they're miserable." Lesley, like Norma, found that she

could help clients to see their problems from a different perspective and rather than simply sharing in their 'misery', she could now help clients "feel ... good about themselves" again (Lesley, 20).

Although she found that she could use SFBT techniques in this way in a ward setting to facilitate 'one-off' patient interactions; she was unable to use her new found skills in a more structured manner. Due to different staff members working in different ways with the same patients, Lesley found it impossible to carry through a 'course of treatment' (for want of a better term) with patients.

"You might have done something one day and thought 'Oh, that's really good, you know, I've made a difference with this patient', go on your days off and then come back and it's all changed; and you kind of felt 'Uh!'".

(Lesley, 39)

Clearly, this was a frustrating experience, and one which was resolved when Lesley began working in a more autonomous role in which she was the only practitioner providing a therapeutic programme for the client she was working with.

"But now it's magic, you know, because you're just left to do whatever you do; so if one week you think, 'It's a really good session. I really feel like we're getting somewhere', there's nobody going to interfere in the next two weeks, you know, when you come back you pick up from where you left off."

(Lesley, 42)

The next cluster of statements I have generated based on my understanding of Lesley's text are:

I drifted into nursing. I was interested in people and what their stories were.

I'm interested in pragmatic communication.

I use SF as a means of communication, as opposed to a 'therapeutic model'.

Unlike Judy, Lesley had no ambition to be a nurse when she was young. She left school and (with all respect to Lesley) followed the path of least resistance towards employment. Her mother suggested that she was 'good with people' and would make a good nurse (Lesley, 52); however, Lesley was not merely 'pushed' into nursing, she was also drawn to it. She had grown up around the local hospital, heard her father's stories of the hospital and had seen patients from the hospital in the local community; all of which had engaged her interest in the patients in the hospital and how they came to be there (Lesley, 56). This draw towards the 'unknown', which the hospital represented, the 'otherness' of the patient's lives took Lesley in the direction, not of 'General Nursing', but towards Learning Disabilities and Mental Health Nursing.

"Oh, my Mum was horrified that I wanted to go to Sangster's Brig, because my Dad had worked there and had these horror stories about what it was like, and Mum's like, 'Sangster's Brig, do you have to go there? Can't you just go to, like, you know, the normal hospital?' (Laughs) 'No, no. I want to go to Sangster's Brig'."

(Lesley, 54)

It would appear, then, that *nursing* itself was not the goal for Lesley, but rather nursing allowed her an opportunity to communicate with, and learn from, people who would otherwise have remained unknown (and possibly, unknowable) to her. I would argue that it is this interest in pragmatic communication that has driven Lesley since. Where Lesley has engaged in study and training to develop her ability to communicate, this has not been a theoretical quest for her; she has expressed little interest in theoretical constructs of 'hidden communication' and 'body-language' for example (Lesley, 70), preferring to focus on communication as a pragmatic means of sharing ideas between two, or more, people. Thus, she had little interest in Rogerian Counselling (Lesley, 66), slightly more interest in CBT (Lesley, 76), but a great deal of interest in BSL (Lesley, 78) because it enabled her to communicate with people with a hearing impairment, and SFBT because it allowed her to communicate in a way that 'made a difference' (Lesley, 20).

Lesley also brought a pragmatic nature to her relationship with SFBT in that she engaged, not with the *model* of SFBT, but with the *practice* of SFBT (Lesley, 98). By this, I mean that she did not come to define herself (or her practice) by SFBT; rather she incorporated SFBT practice into her own repertoire of therapeutic talk. Taking aspects of CBT that she found useful (interestingly, although Lesley was trained in formal CBT, it is the 'CBT-inspired' self-help materials, developed by Dr Chris Williams that she finds most useful from this approach) and mixing that with SF inspired conversations, she takes a 'non-purist' stance towards her practice. In this she appears to be led by the client's needs; a position that is in keeping with her expressed disregard for 'expert status' therapeutic styles (Lesley, 71).

"I couldn't say it's a model no. No. I could say that I use solution focused techniques but ... sometimes it's definitely solution focused and I know that's definitely what I'm doing, and that's what I'll say, and sometimes it's CBT but it's, well you couldn't really say 'proper' CBT because it's not sixteen sessions, but you would definitely sometimes say 'this is a solution focused approach', 'this is a CBT approach', but most of the time I would say it's mixed."

(Lesley, 96)

Thus, Lesley uses SFBT as an aid to communication; not as a *therapeutic tool*, but rather, as a *style of interaction* between herself and the client she is engaging with. This leads then, to the final two statements I would make with regard to Lesley's text.

I do not intellectualise; I'm a people person. I engage and communicate at an emotional level.

SFT enables me to engage with people and help them – that's what I want to do.

I would imagine that, by this point, it is clear that Lesley engages with her role as a nurse at an 'emotional' level. She does not aim to understand the underlying problems that bring people to mental health services, nor does she seek to analyse the behaviours that maintain those problems; rather, she seeks to engage with the client at a 'personal' level, person-to-person, and to help them improve the quality of their life – to 'make a difference' in other words. It is this ability to communicate effectively and therapeutically that defines Lesley's concept of Mental Health Nursing.

“I’m interested in people. I’m interested in what they say. I’m interested in how they react and respond to different situations so yeah it suits me fine that I can do that, you know, in the context of my job”

(Lesley, 107)

SFBT thus enables Lesley to have the conversations that she wanted to have before; it provided her with a framework within which she could structure her communication in such a way that she was able to help clients improve their lives without her adopting an ‘expert’ stance in relation to the client or their problems. This was the goal that brought her into nursing and has followed her through her career.

“Well for me, Mental Health Nursing; your main skill that you have to have is communication. Good communication skills. If you don’t have that, for me, it’s pointless whatever you do. I think I would have always sort of thought that and wanted to, you know, that’s why I, sort of, came in to nursing and I think that’s, that would sort of follow me through.”

(Lesley, 108)

I would therefore encapsulate my interpretation of Lesley’s text in the following statements.

- SFT gave me the skills to communicate more effectively with people.
- SFT enabled me to make a difference in people’s lives.

- I did not feel valued in a team setting – I can make a difference in my current role.
- I drifted into nursing. I was interested in people and what their stories were.
- I'm interested in pragmatic communication.
- I use SF as a means of communication, as opposed to a 'therapeutic model'.
- I do not intellectualise; I'm a people person. I engage and communicate at an emotional level.
- SFT enables me to engage with people and help them – that's what I want to do.

I would summarise this by saying that, for Lesley, SFBT is about communication; it is a means for effectively forging therapeutic relationships with clients and it is these relationships which are important to Lesley.

SFBT provided Lesley with an epistemological framework within which to relate her ontology to her practice. I would suggest that her ontological standpoint is one in which the 'person' is of prime importance, and the relationships between people. For Lesley, 'Being' is 'Being-with' (Heidegger's Dasein as Mit-sein), she exists in context to other people and it is this context, that of 'caring about people', that defines her methodological standpoint to practice. In this she eschews abstract theoretical models of practice in favour of practical pragmatics; it is through the process of 'communication' that one engages with the other, the 'therapeutic use of self' by which Lesley seeks to explore the world of the other. In this there are no 'right' or

'wrong' understandings, only those which are more or less helpful to the client, and in SFBT Lesley found a way of working that mirrored that position. Like her, SFBT favours a practical framework for engaging with the other and, as such, offers an epistemological basis for her practice. For Lesley, the basis of nursing knowledge is practice – 'how to do it' – again, a pragmatic position reflecting the SF ethos of 'if it works – do more of it' and 'if it doesn't work – stop doing it' (Hawkes et al, 1998). Like Judy, Lesley did not speak of a formal knowledge base of nursing, explicitly suggesting that the basis of good nursing is communication (Lesley, 109) and the acquisition of that knowledge / skill is experiential.

9.5 Conclusion

In conclusion, training in SFBT provided Lesley with two inter-related things. It provided her with an epistemological framework to relate her ontological outlook to her practice, something that had been lacking previously. In more practical terms (terms which Lesley would more readily express, perhaps) it provided her with a communication framework within which she could make a difference in the lives of the people she worked with. It would appear to be this that she valued most.

Chapter 10: Discussion on Stage II

10.1 Chapter Overview

In this chapter the connections, in relation to mode of working and satisfaction with the SFBT training experience, which I had posited at the conclusion of Chapter Five, will be reviewed in light of my understanding of the three texts above. That understanding will then be explored from the perspective of Jaqueline Fawcett's metaparadigm of nursing. The emergent nursing paradigm informing the practice of each of the participants will be described and synthesised, and I will then use Fawcett's model to describe a metaparadigm of SF practice. Finally, a 'fusion of horizons, that is, my understanding of why the three participants had the experience they did - shall be presented.

10.2 Review

At the end of Chapter Five I suggested that there may be a link between the levels of satisfaction participants experienced from training in SFBT and their work environment. Specifically, I had suggested that participants who worked in a ward or team setting were less likely to be satisfied with their experience of training than their counterparts who worked in an autonomous role. My assumption was that participants who worked in a ward / team setting had less opportunity to practice SFBT due to a number of constraints including, lack of time to spend with patients in one-to-one conversation, little opportunity to plan and follow through with proactive care, predominance of 'Consultant sanctioned' CBT model, and the need for the Team to work together. Analysis of the three Stage II interviews

provided little to support that assumption. It is true that all three participants spoke of their experience of Consultant Psychiatrists wishing to prescribe nursing interventions, and all three spoke of the need for nurses to work as part of a team; however, both Dawn and Lesley spoke of how SFBT can be used effectively in a ward setting. Lesley, it is true, gave a coherent account of some of the problems she encountered using SFBT in a ward setting, but both she and Dawn clearly stated that SFBT was an effective tool, particularly where a brief intervention was required. Equally, Judy stated that although she was now working in a more autonomous role, she still did not practice in an SFBT mode. Clearly, my assumption based on the typology of experience generated in Stage I was not supported by the data generated in Stage II.

So what, if any, was the connection between working in an autonomous role and degree of satisfaction in the SFBT training experience? Having recognised what 'was not there', I began to search for 'what was there', and asked myself if the link was one of experience. Was it the case, I asked myself (and the texts), that less experienced nurses tended to practice in a ward / team setting and progressed to an autonomous role as their experience increased. Equally, did the less experienced nurse rely more on the core-skills and knowledge of nursing and, therefore, only come to value the principles and practice of SFBT as their knowledge grew? Gratifying as this line of thought was, it was clearly a mistake. My questioning of the texts I was dealing with had changed from "What is it ...?" and "Why is it ...?" to "Is it not so ...?", in other words I was no longer seeking emergent understanding from the text so much as I was seeking to impose understanding upon the text. Gadamer clearly states that understanding occurs when meaning 'asserts itself' through an event (Gadamer, 1979. p446); there is a sense here of *understanding* 'cutting across the bows' of our engagement with a text. Davies (2006) emphasises this point:

“Hermeneutic encounters reveal the ‘negativity of experience’: a hermeneutic experience worthy of the name *disrupts* the expectancies one has of an artwork or text so that one is forced to think again.”

(p.12)

Not only was there nothing in any of the three texts to support the notion that SFBT was an ‘advanced practice’ satisfying only to experienced practitioners, but it would be insulting to seriously suggest so. While Judy was the youngest and least experienced of the three participants, she was far from *inexperienced* and, while she was highly satisfied with her role in the nursing team, Dawn and Lesley both implied that they had become dissatisfied with their role as a nurse by a similar point in their careers. It, therefore, became apparent to me that the relationship between place of work and satisfaction with the SFBT training experience may be no more than a coincidence. Indeed, recognising that, in the period between Stage I interviews and Stage II interviews, Dawn and Judy had both moved from one work environment to another, and that Lesley had made a similar move just shortly before the first interview, I was reminded that the observation of patterns is an arbitrary action on the part of the observer and does not require any actual relationship between the parts of the observed (Watzlawick, 1976). Had I observed Dawn, Judy and Lesley at another point in time, their work environments may have been quite different and the ‘patterns’ I saw consequently different too.

10.3 Metaparadigms of Nursing

What emerged for me from the texts was a sense of the three participants as discrete *individuals*. Indeed, I began to think of them (stereotypically) as **The Rebel** (Dawn), **The Nurse** (Judy) and **The Communicator** (Lesley); whilst this was, essentially, reductionist in nature (and not an approach I actively pursued), it did highlight for me the understanding that they all brought a different *schema* to the interviews we shared. Each of the participants had her own, unique, vision of what it was to be a nurse, and I came to recognise that each of the texts gave an insight into how each participant conceptualised nursing; the paradigm by which she defined (consciously, or not) her professional activities.

It is now thirty years since Jacqueline Fawcett (1984) formalised the concept of the *metaparadigm of nursing*; however, the idea has been refined and developed over the intervening period (Fawcett, 2005), maintaining its relevance for contemporary practice (Lee and Fawcett, 2013). That is not to say that the model is universally accepted within the nursing community. Oliver Slevin (2003) among others (Conway, 1985; Meleis, 1997) has argued that Fawcett's inclusion of 'Nursing' as a discrete concept within her metaparadigm is fundamentally flawed in that, if the metaparadigm is to define nursing, the inclusion of nursing as a constituent part of the definition results in a tautological statement of the type, '*nursing is nursing*' (Slevin, 2003). Slevin goes on to suggest that 'Caring' would provide a more appropriate terminology for the activity Fawcett seeks to describe; Fawcett for her part has rejected Slevin's criticism (Fawcett and DeSanto-Madeya, 2013), arguing that her concept of Nursing reflects the *activity* of nursing as opposed to the overarching *Discipline of Nursing*. Central to this discourse would appear to be the understanding of whether *nursing* amounts to something more than *caring* (as suggested by Fawcett's position) or whether the two terms are synonymous (as suggested by Slevin's position). It could certainly be argued that *nursing* can be seen as a more pro-active concept, encapsulating, as it

does, notions of growth and nourishing the other, whilst *caring* can be viewed as a more re-active position in the context of remedial action where the other is unable to care for themselves - a position that I would certainly endorse.

On the other hand, Fawcett's metaparadigm has also been criticised on the basis that the other three concepts contained in the construct are not unique to nursing. Cody (1996) argues that,

"After due reflection on the claim that the four concepts taken with the four propositions reflect the unique focus (or foci) of nursing, this author finds the claim unmerited in that many disciplines beside nursing study three of the four concepts - person, environment, and health - and many disciplines study the relationships described in the four propositions with the exception of those including nursing per se."

(pp. 97 - 98)

Fawcett, again, rejects the criticism made on the basis that Cody fails to recognise the special significance these concepts have for nursing, arguing for example that *health* in a nursing context encompasses wellness and illness, "whereas other disciplines regard health as wellness and illness as disease" (Fawcett and DeSanto-Madeya, 2013. p.7). Clearly, Fawcett does not identify these *other disciplines*, and as a result her defence here has a somewhat hollow ring to it. Kim (2000), while supporting the importance of the metaparadigm, offers an alternative set of concepts: *Human living of oneself; human living with others; living in situations*. While this approach emphasises the intra- and inter-personal nature of living in a specific context, it arguably (for me) fails to address the richness of experience that Fawcett's understanding encompasses. For these reasons, and as

Fawcett's proposal is, arguably, the "most widely recognised" (Slevin, 2003. p. 158), it is Fawcett's metaparadigm that is selected for use here.

The metaparadigm of nursing, as described by Fawcett, comprises "four concepts, four nonrelational propositions, and four relational propositions" (Fawcett, 2005. p6.) The four concepts are **Human Beings** (refined from the earlier conceptual label 'Person'), **Environment, Health** and **Nursing** (Fawcett and DeSanto-Madeya, 2013). The definition of these concepts (the 'nonrelational propositions') is shown in Table 2.

Human Beings refers to the individuals, if individuals are recognised in a culture, as well as to the families, communities, and other groups or aggregates who are participants in nursing.

Environment refers to human beings' significant others and physical surroundings, as well as to the settings in which nursing occurs, which range from private homes to health-care facilities to society as a whole. The metaparadigm concept of environment also refers to all local, regional, national and worldwide cultural, social, political and economic conditions that are associated with human beings' health.

Health refers to human processes of living and dying.

Nursing refers to the definition of nursing, the actions taken by nurses on behalf of or in conjunction with human beings, and the goals and outcomes of nursing actions. Nursing actions are viewed as a mutual process between the participants in nursing and nurses. The process encompasses activities that are frequently referred to as assessment; labelling, or what some nurses refer to as diagnosis; planning, intervention and evaluation.

Table 2: The nonrelational propositions defining the metaparadigm concepts. (Fawcett and DeSanto-Madeya, 2013. p. 6)

If the metaparadigm of nursing is used as a framework through which to view the texts of the participants in Stage II, the specific differences in the nursing paradigm each participant is enacting can be more clearly seen. (In order to do this, I mapped my understanding of each text to the four metaparadigms described by Fawcett. This did not affect the genuine quality of the interpretation of the texts; rather it viewed that interpretation through a specific, identifiable lens in order to discuss it in a particular context.)

10.3.1 Dawn

Human Beings, as described by Dawn, are self-actualising, complex social beings, responsible for their own wellbeing. While she is committed to working with individuals to help them enhance their mental health, her role in this is that of a facilitator, as opposed to a provider. She describes an interactive partnership in which she helps the patient envisage a positive future scenario and identify some of the next steps to approaching that situation, but leaves the patient to take those steps in their own time.

“I still leave it with them because I’m not going to do it for them, but it’s still looking at – they’re still looking – they’re still thinking of it as a problem, but they’ve actually come up with the solution themselves; and I leave them with it.”

(Dawn, 9)

The Human Being that Dawn interacts with is a *Person*. This is a relevant distinction in that, Leininger (2006) argued that the original metaparadigm concept of 'person' was limiting in so much as the concept of an individual person was not a meaningful, or dominant term used in some non-Western cultures. She argued that, from a transcultural perspective,

"the linguistic terms of *human beings, families, clans, and collective groups* are frequently used transculturally because the terms have cultural meanings and are often used by the people."

(Leininger, 2006. p.9)

Although she had initially rejected earlier versions of this argument (Fawcett, 2000), Fawcett came to acknowledge it and, recognising that her original concept of 'person' was, in itself, adapted from Yura and Torres' concept of 'man' (in order to utilise a non-gender specific terminology), she has subsequently further adapted the concept of 'person' to that of the non-culture specific term, 'human beings'.

However, the concept *Human Being* as used by Dawn clearly reflects a Western perspective relating to an 'individual person'. In discussing this, she makes a clear distinction between seeing the person as a 'whole' person, and seeing only a diagnosis or label; in working with the person to help them develop and adapt in response to their current situation, as opposed to trying to simply reduce their 'dysfunctional thinking' or non-wanted behaviour. In doing this, she is led by what the patient wants, trusting them as individuals to know what they want from their life, seeing them as the expert in their own lives and working with them to help achieve those goals.

Dawn spoke in terms of nursing taking place in a ward **Environment**; one of team working, often medically led, but which does allow for different outlooks among practitioners. The Consultant psychiatrist is often the *de-facto* team leader, in some cases prescribing nursing interventions and, in others, 'allowing' nurses to determine the nature of nursing interventions for themselves. The nursing environment is largely centred on task-focused activities, with a significant focus on 'paper-work' and ward administration. Dawn described a tension between the needs of the 'Ward Team' (focused on the management of the ward, nurse led) and the 'Consultant Team' (focused on clinical care, medical led), caused by people performing multiple roles with (potentially) conflicting goals. Out of this environment, Dawn described the focus of her activities as being about 'working with the client'. Her goal is to help the client focus on the future and to work with them to explore how to achieve a more positive future. She noted that much of the 'paper work' mentioned earlier was becoming more focused on this goal too.

It would appear to me that Dawn is describing an environment in transition; a place where Scottish Government policy and Health Board guidelines (and associated paperwork) support a future-focused, client-led journey to mental health recovery, one in which the ethos of SFBT is reflected implicitly, if not explicitly.

Dawn said little about the concept of **Health**. It is certainly present in the text, but as a *context* against which other issues are discussed, as opposed to a topic of discussion in its own right; it could be argued that this is how Fawcett intended the concept to be understood – the "human processes of living and dying" (Fawcett and DeSanto-Madeya, 2013. p. 6) that are the context in which nursing interactions take

place. It can be seen however, that Dawn conceptualises Health as a multi-faceted, integrated whole in which the person is able to exercise choice in order to overcome, or reduce, the 'problem-nature' of their complaint. It is, most importantly in Dawn's view, an emic state (Pike, 1954) in which the patient perceives their own state of health on a continuum from 'poor' to 'good' (often, in Dawn's case, measured on a scale from 0 to 10) and has ultimate responsibility for bringing about its change. In short, it could be said that 'Health' is the state reflected in the solution to the patient's problems, as described by the patient.

In relation to **Nursing**, Dawn spoke of the Nurse as a team worker who, never the less, is able to incorporate her own ideas into her approach to care. Nursing is seen by Dawn as very much a 'team exercise'; nurses practise as part of a *nursing team* and as part of a *clinical team* (sometimes referred to as a Multi-Disciplinary Team), the former are defined by where they work (the ward team), and gradations thereof (the blue team, for example), and are led by the senior nurse on duty while the latter are defined by, and led by the Consultant Psychiatrist (the Responsible Medical Officer for that team). As well as having to operate within the explicit (and sometimes conflicting) expectations of both teams, nurses also have to work within the implicit expectations of both teams; a situation which Dawn found allowed her a degree of freedom to incorporate her own ways of working into a complex work dynamic. This would include introducing SF practice into her role even when explicitly practising in a problem-focused manner.

The key role for a nurse in Dawn's view is one in which she encourages patients to explore and take responsibility for their health status; she spends time with patients in order to initiate change. There is a sense of *nurturing* inherent in Dawn's vision of nursing; her role is not to provide for patients, but to facilitate the acquisition of skills whereby

the patient can provide for themselves. As a professional practitioner, this is done in a structured, evidence-based manner; however, it is also something that is *internalised* by the nurse and which she engages the patient through. In other words; nursing is something you *do with* patients, it's not something you *do to* patients.

10.3.2 Judy

Human Beings are discussed by Judy in the context of *patients*. As such they are seen as the recipients of care. The patient is a person who requires to have their needs assessed and to have some form of care provided for them. Judy describes this, as a central aspect of her role with patients, thus;

“... just giving explanation and finding out why they think that they're here and what their problem kind of is, to ease them into, you know, building a kind of more therapeutic engagement to then kind of complete all the rest of the [assessment]”

(Judy, 24)

The 'therapeutic relationship' Judy describes is one of a pragmatic nature in which the relationship is not 'therapeutic' in and of itself, but rather is therapeutic in that it leads to a richer assessment of the client's needs, which are then conveyed back to the therapeutic team. It is clearly important to Judy that each human being is seen as an individual, in the sense that they are not to be seen as 'a commodity', or as simply 'a patient'; they are a unique, individual person with their own world view and perspective. This understanding, however, exists

in the context of a medical model of care, and thus the patient is a unique individual with a classifiable illness.

The **Environment** in which this takes place is one of team working; the team works by consensus, but is medically led and responds to the needs of the hospital. Judy spoke of the team in terms of a Consultant-led, multi-disciplinary team. The team met regularly and discussed new referrals and existing patients; however, despite the appearance of democratic process, Judy (like Dawn) spoke of the Consultant Psychiatrist as the *de-facto* team leader, having the deciding vote where the team could not reach *the correct* decision. The way in which the team operates, while allowing some allowance of personal style, is largely mandated by 'the service' and is designed to best meet the needs of the service in delivering services to patients, thereby meeting the health needs of the community.

Health then, in Judy's view, is a state where one's health needs are met; an absence of illness or limitation. Like Dawn, Judy did not say a great deal about health; however, assuming that the nurse's role is to promote health in some way, and given that central to Judy's role is the assessment of patient's needs and the provision of care to meet those needs, it can be argued that a 'healthy person' is one who's health needs are met, either independently or by service provision.

Specifically, Judy (like Dawn) describes **Nursing** as a team activity; the nurse is a *team worker* who is *directed in what she does by the Doctor*. She *carries out assessments* and *gathers baseline data* on patients' needs, conveying this back to the team where decisions are made and the nurse then delivers an agreed healthcare option to the patient. She is an *information giver*, both to the team and to the

patient, and fulfils a '*back stage*' *caring role*, a role in which her efforts may not always be apparent but which are essential to the care (as opposed to the more dramatic 'cure') of the patient. Judy recognises that in doing this she is not operating in a haphazard manner but is rather, working within a *structured approach*, designed to bring together the needs of the service and the patient, and to meet both.

10.3.3 Lesley

Lesley discusses **Human Beings** in the context of the individual person. She sees the individual as being a source of *strengths and abilities*, a *social being with mixed needs*. Lesley described the patients she worked with as having all the strengths and abilities required to overcome (or live with) the problems they were experiencing, and it was helping the person access these qualities that she saw as the central part of her role. She argued that the person *leads their own therapeutic journey* and *perceives their own health status*; in this then, they were the expert and she the facilitator of that expertise. In interacting with patients she was led by this, whether that be in agreeing the goals of treatment or in deciding what it was that they were going to talk about. Having said that, she also believed that people define themselves by the *stories they tell* and in this context she sought to engage people in stories of strength and coping.

The **Environment** that these conversations occurred in is contextual in that it responds to the wider environment it is placed in. According to Lesley ward-based care can be *task focused* and is based on *Team working*, often following the *medical model* of care. This was the environment she had previously worked in and found that although the team environment of the ward setting did not encourage the

application of SFBT, it was possible to introduce some aspects of it into her own practice. In this she echoed aspects of both Dawn and Judy. Lesley, however, felt that *working autonomously* involves more of a relationship with the patient. In this setting she was able to focus more on her own developing style of practice, and was less dependent on a team of practitioners to support her activities. She argued that people respond in different ways to *different environments*, and therefore she worked to facilitate the environment most conducive to positive change; whatever that might be.

Like her two counterparts in the study, Lesley says little about **Health**. It is, like the other two texts, in the background of her conversation and sets the context for her discussion. For Lesley, Health is a self-determined state not related to illness; it is *contextual and perceptual* in the sense that (as discussed above) it is dependent on how one sees one's situation. Thus, Lesley is able to help the clients she works with by helping them 'approach their problem in a different way' and by speaking about 'where they want to be', allowing them to see their current situation in a different context and from a different frame of reference.

In light of this, it follows that Lesley sees the role of **Nursing** as being about communication. The Nurse *communicates with people (patients), spending time with them to help them find their strengths*. This, then, is a different role from that described by Judy. Here, Lesley does not deliver services to the patient in order to overcome their presenting condition but, rather, she seeks to help the patient explore the existing strengths they already possess, in order to overcome their presenting condition. It can be seen that, although she refers to Team Working as the environment in which Nursing takes place, Lesley tends to describe Nursing as a one-to-one relationship between nurse and patient / client. Most importantly, for Lesley the

nurse is *interested in people and cares about them*. This *caring* is central to Lesley's practice, "I don't think you have anything if you don't have love in your life" (Lesley, 102); from this it may be possible to hear echoes of Carl Rogers' emphasis on the therapeutic importance of *unconditional positive regard* in the context of self-actualising beings (Rogers, 1957). Thus, for Lesley, Nursing is *interpersonal and contextual*.

10.3.4 Similarities and Differences

It can be seen that there are a number of similarities and differences discernible between the three texts when they are read in the context of the metaparadigm of nursing. Most clearly, all three texts agree that the **Environment** in which nursing takes place is, largely, a team working environment. This is most evident when nursing takes place in a ward setting, and is most often operationalised around a 'medical model' approach to working, reflecting the dominance of this approach in Western mental healthcare (Shah and Mountain, 2007). All three texts also agree that there is a form of consensus involved in the way in which the Nursing / Multi-disciplinary Team operate; a shared, implicit understanding of unspoken rules relating to power structures and modes of behaviour; however, these rules can be manipulated allowing for, both, some degree of individualised practice, when successful, and stress and conflict, when unsuccessful. Another area where all three texts share an understanding is in their treatment of the metaparadigm concept of **Health**. In all three texts Health is a, somewhat, nebulous background against which the narrative of nursing practice takes place. Broadly speaking, Health is about 'getting on with life', being an 'integrated whole' and is 'contextual'. There is some shared understanding of the **Human Being** in so much as the concept is understood as an individual person; the individuality of the person / patient / client being stressed in all three texts (there

are also some differences in the way this individuality is conceived of, this is discussed below). There are fewer similarities in the way in which the three texts deal with the paradigm concept of **Nursing**. Dawn and Judy both explicitly describe the nurse as a team worker, although they respond to this in different ways. Where Judy accepts the Team Worker role and is developing within that structure, this is the aspect of nursing that Dawn essentially rebels against; in a sense (it has come to appear to me), it is this definition of Nursing that Dawn (**The Rebel**) rebels against, and which Judy (**The Nurse**) accepts.

Although there are fewer differences between the positions described in the texts than there are similarities, the differences are more significant in defining the participant's approach to Nursing. Although there are similarities in their understanding of the concept of **Human Being**, there are also differences. For Lesley and Dawn, the human being who is the patient (or client) is the expert in their own life; they are an equal partner in their healthcare and are responsible for their own wellbeing. For Judy, the patient is seen as the recipient of care; they may be an equal partner in choosing the healthcare package on offer, but their *illness* is a discrete entity to be treated, as opposed to the idiosyncratic experience of the patient's perceived by Lesley and Dawn. Following from this, in a similar manner, the texts differ in their understanding of **Nursing**. For Judy, the Nurse is an assessor, a conveyor of information between the team and the patient (and vice versa) and a provider of care. For Dawn, the Nurse is someone who facilitates the patient's exploration of self, a *change agent* who enables the patient to explore positive future scenarios and promotes choice. For Lesley, the Nurse is a communicator, a facilitator of discovery and change. There are clear similarities in the concept of Nursing described by Lesley and Dawn, and a clear difference between that concept and the one described by Judy.

10.3.5 Towards a Solution Focused Paradigm

It might be useful, at this point, to contrast the individual paradigms (if such a concept can be allowed) of nursing expressed by each of the participants with a solution focused paradigm. Since the inception of the SF model there has been a paucity of *theorising* about any aspect of SF practice in the literature. This began with De Shazer's assertion (1994) that he did not intend to develop, nor had he developed, a "Theory, or Grand Design" (p. 274) of SF practice; Hanton (2011) argues that this point has possibly been misunderstood over the years and that SFBT is not anti-theoretical, it simply does not have "an underlying (grand) theory" (p. 5). Indeed, while avoiding the generation of any Grand Theory, De Shazer (1994) discusses the work of, among others, Lacan, Derrida and (most often) Wittgenstein in the evolution of his thinking. Misunderstanding or not, there has however been a reluctance on the part of writers about SFBT to explicitly discuss a theoretical basis for what they do. And so, the question has been asked, 'Does a Solution Focused Paradigm exist?' (McKergow, 2009). McKergow found opinion among the SF practitioners to whom he spoke split on the existence of an explicitly SF paradigm, which, by definition (Kuhn, 2012) ought to mean that no such paradigm exists.

Nonetheless, there are two counter-arguments to this. Firstly, while avoiding theorising about SF practice, many writers (Hawkes et al, 1998; Iveson, 2003; Hanton, 2011; Macdonald, 2011) have *described* their practice and the assumptions underpinning it, many of these assumptions are discussed in Chapter Three, and these *shared* assumptions begin to define what the appropriate norms, concepts, uses and measurement of SF practice shall be. In other words, they begin to define the paradigm within which SF practitioners function. Indeed, when Kuhn discussed previous paradigmatic models of practice, he argued that they shared two essential features;

“Their achievement was sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific activity. Simultaneously, it was sufficiently open-ended to leave all sorts of problems for the redefined group of practitioners to solve.”

(Kuhn, 2012. p. 10/11)

If one were to allow a sufficiently broad definition of the term ‘scientific enquiry’ to include the practice of SF interactions, then Kuhn’s observation could be seen to describe the activity within the SF community over the past 25 years.

Secondly, there are numerous enacted examples within the literature of the acceptance of a SF paradigm within the wider SF community. Flatt and Curtis (2013) explicitly refer to a ‘Solution-Focused Paradigm’, as does Grant (2011) while others (Montgomery and Webster, 1994; Popescu, 2005; Lamarre, 2005; Walsh, 2010) refer to the emergence of SF activity as a ‘paradigm shift’ in therapeutic thinking. Clarke (2012) goes so far as to paraphrase Kuhn (1957) in her description of SF as ‘another Copernican revolution’; it could, therefore, be argued that there is something that many SF writers do consider to be a specific SF paradigm. Unfortunately, such a paradigm has never been explicitly defined.

It is, however, possible to construct a metaparadigm of SF interactions based on the underpinning assumptions and practice contained in the literature, and reflecting the structure developed by Fawcett. Such a metaparadigm would include four concepts, four non-relational propositions and four relational propositions (see Table 3 below).

Furthermore it must meet the four requirements for a metaparadigm established by Fawcett, these are that the metaparadigm must,

“identify a domain that is distinctive from the domains of other disciplines, encompass all phenomena of interest to the discipline in a parsimonious manner, be perspective-neutral and be international in scope and substance”.

(Fawcett and DeSanto-Madeya, 2013. p. 5).

It can be seen that one of the four concepts comprising the metaparadigm of SF Interactions is held in common with Fawcett’s metaparadigm of nursing. In keeping with the literature, the **Environment** is a multi-contextual concept which includes the physical environment where the interaction takes place, the perceived ‘future’ environment wherein a Positive Future Scenario is enacted (O’Connell, 2003), and it is ‘utilising’ what the client brings with them (Hanton, 2011. p. 24). Of the other three concepts; the different domains of ‘nursing’ and ‘SF interactions’ mean that some change to Fawcett’s concepts is required.

The concept Human Being is too broad based for the SF metaparadigm, SF practice engages with Human Beings at an individual level (regardless of whether they are seen individually or in groups) and so the term ‘client’ initially appeared to me a suitable replacement. However, ‘client’ does not meet the requirement to ‘encompass all phenomena of interest to the discipline in a parsimonious manner’, for example it would not encompass SF research; therefore, I adapted my initial thinking and utilised

Metaparadigm of Solution Focused Interactions.

Concepts:

- Participant
- Environment
- Solution
- Practitioner

Nonrelational Propositions:

- **Participant**

Participant is the 'expert in their own life', they are the source of the *solution*. It has always been clearly understood that the client 'knows what they want, they just do not know that they know it'. (De Shazer et al, 1986) Where the problem is discussed (and this is not a necessary requirement of SF interactions), the participant defines the problem i.e. it is not defined by a third party who then *sends the participant* for help. More importantly, the participant co-constructs the solution; they are an active part in an active process, *they are the source of the solution*. The participant may be an individual or group (purposeful / familial / organisational or otherwise), they are the possessor of a store of strengths, assets and abilities. They are *not* the problem.

- **Environment**

At a global level, the environment is where we interact with others, and includes those others as part of that environment. Contextually it is the stage upon which change happens. Metaphorically it is the future; it is where change *will* happen. Dynamically it is the collaborative relationship between participant and practitioner.

- **Solution**

Solutions are defined by the participant. A solution state is a state where the participant has achieved whatever their 'best hopes' were for the given situation when they entered into the interaction(s), to their satisfaction. Solutions are a rich and diverse experience; a 'positive' state where, for whatever reason, the participant no longer feels burdened by the problem that brought them to the interaction. However, solutions are not directly linked to 'problems' and are certainly not simply the 'absence of a problem'.

- **Practitioner**

Practitioner is an active co-constructor of solutions. They are curious and 'not knowing'; they know that they *may know* how to help build solutions, but that they *do not know* how to solve problems. They ask helpful questions of the participant in order to elicit incidence of 'difference' in the participant's experience. They amplify and reinforce change that has occurred in the participant's experience (they *do not* create or suggest change, they *note* change where it has happened) and assist the participant to do more of what the participant considers 'is working for them' at the moment.

Relational Propositions

- Solution Focused Interactions are concerned with the wellbeing and optimal functioning of human beings.
- Solution Focused Interactions are concerned with human behaviour in interaction with the environment in normal and critical life situations.
- Solution Focused Interactions are concerned with the actions and interactions by which positive change is brought about.
- Solution Focused Interactions are concerned with the wellbeing of human beings, recognising that they are in continuous interaction with their environment.

Table 3: Metaparadigm of Solution Focused Interactions.

the term **Participant**. This resonates with the key SF principle (De Shazer et al, 1986) of working with the 'client' to *co-construct* solutions; the 'client' is an equal participant in the undertaking.

Equally, the concept of 'nurse' was inappropriate to a metaparadigm that would encompass other professional disciplines (and would not encompass all aspects of nursing). In keeping with Fawcett's requirement that the metaparadigm be 'be perspective-neutral and international in scope and substance', I utilised the term **Practitioner**, which is perspective-neutral and recognises that, in whatever domain of practice the interaction takes place, be it psychotherapy (De Shazer and Dolan, 2007), organisations (Jackson and McKergow, 2007) or nursing (McAllister, 2007), the facilitator of the session is *practising* in a SF manner. The final concept is that of **Solution**; this is analogous to Fawcett's concept of 'health', but is specific to the domain of SF practice. Where promoting 'health' is, arguably, the goal of nursing, promoting solutions is undoubtedly the goal of SF practice.

Having constructed a (provisional) SF metaparadigm, it can be seen that the paradigms of nursing practice described by both Dawn and Lesley are more closely aligned to a SF paradigm than is the paradigm described by Judy. While Dawn and Lesley perceive the participant in their endeavours to be the individual who defines what their problem is and is an equal participant in co-constructing a solution, Judy describes a more passive role to her patient. Equally, where Judy delivers a care package to patients, fulfilling something of an 'expert' role, Lesley and Dawn describe a greater degree of curiosity about their client's existence. Finally, it is evident from Judy's text that within the paradigm in which she operates there is a 'correct answer' (or number of potential correct answers), an evidence-based treatment that can be offered to the patient; in the other two texts it is clear that the 'answer' comes from the patient / client / participant themselves, the *solution* is defined by the participant.

10.4 Fusion of Horizons

Although none of the participants claimed to work to a specific 'model' of practice, if I were to link their narratives to a specific model of nursing, I would associate the position described by Dawn and Lesley with the work of Hildegard Peplau (1988), and of Professor Annie Altschul (1972); indeed, Altschul highlights several of the points raised by Lesley and Dawn, in an editorial published in 1999. Discussing her experience of observing nurses during her 1958 visit to the USA, she observed,

"They [student nurses] only saw a function for psychiatric nurses in private practice, where it would be possible to have a well defined case load of patients, all to themselves. I could not understand that point of view at the time but I have now come round to it. It was the intermittent, time restricted, intensive one-to-one relationship they valued, the knowledge that the patient recognized them as specifically theirs, that every patient was entitled to undivided attention from the nurse. Perhaps the attraction of community psychiatric nursing is due to an experience similar to the one which nursing students were able to find in the wards when there was just the one patient they saw every time they came to the ward. Giving attention to a ward full of patients is too emotionally draining for nurses, as is the giving of full time attention to one patient by a caring relative. A little arithmetic is not out of place if one is to consider the significance of nurses' relationships with patients. How many relationships with patients can a nurse be expected to sustain at any one time? How many during the course of a career? How many therapeutic relationships can a hospitalized patient form with nursing staff? How many members of staff does a patient meet if the stay in hospital is prolonged?"

(Altschul, 1999. p.262)

Equally, I would associate the position described by Judy with the work of Roper, Logan and Tierney (1996). Given that I had identified Judy with **The Nurse**, this is not surprising; Roper, Logan and Tierney's model of nursing is the "most

common model in the UK" (Siviter, 2008. p.39), and although the model was designed as a comprehensive model of care, Roper herself has recognised that in practice it is most often used as "a paper exercise" (Roper, cited in Siviter, 2008. p.1). By this, I do not mean to suggest that Judy's practice is 'a paper exercise', but that Roper, Logan and Tierney's model has become something of an 'assessment tool' associated with the *nursing process* of Assess, Plan, Implement, and Evaluate; in other words, a tool for assessing and meeting the patient's needs, the process described in Judy's narrative.

I would, therefore, argue that the practice described in all three texts reflects established models of practice in contemporary mental health nursing. One (Judy's) reflects an assessment and delivery model based around the Activities of Daily Living (Roper, Logan and Tierney, 1996), whilst the other two reflect an interpersonal, dynamic model based on shared relationships (Altschul, 1972). While all three share a similar understanding of some of the conceptual metaparadigms of nursing, they differ primarily in their conceptualisation of Nursing; what it is that Nursing is about. Equally, of the three texts, the two which report greater satisfaction with the training experience are the two which most closely match the SF metaparadigm described here.

I believe it is this that illuminates the difference in satisfaction the three participants had in their experience of training in SFBT. For Judy, who, as we have seen, is practising within the dominant model of nursing in the UK ('doing what nurses *do*') there is little incentive to practice in SFBT; the approach is not utilised by other team members and it adds little to the process of needs assessment and resource delivery utilised within that model of nursing. Furthermore, Judy is happy to practise within that model, there is no dissonance between her ontological position and the epistemology and methodology of her practice. On the other hand, Dawn and Lesley, while practising in the same nursing environment, seek to practise in a different way. Both participants spoke of being ready to change their practice when they commenced the SFBT training course, and both expressed an ontological perspective more closely

aligned to an interpersonal therapeutic role than an assessor-provider role. Both these participants described an ontological perspective more closely aligned to the SF paradigm of practice than did Judy. Additionally, although they both recognised the need to work within the wider team, both expressed an inclination towards individualised practice; therefore, for them, training in SFBT offered a viable alternative to their current practice. Training in SFBT enabled them to deliver a client-led, individualised therapeutic interaction in which they could perform a therapeutic role without assuming an 'expert position'; in other words, the training allowed them to practise in a manner that is congruent with both an evidence-based body of clinical knowledge relevant to nursing practice, and their own personal values and beliefs.

This, of course, is not a new perspective to take. Piaget (1975), and other constructivist theorists, argued that learning is a process of assimilations and accommodations, building on what the learner already knows and understands of the world. It can be seen that the transformation to a state of being a SFBT practitioner is only a logically sound proposition if that state is congruent with one's current knowledge and understanding. Importantly, the experience of training in SFBT has to be, not only relevant to the participant's current understanding, but must also be relevant to their expectations of future practice. Moore (2012) notes:

"An important point here is that assimilation and accommodation do not only enable us to make sense of the world, but that sense-making itself contributes, each time, to the way we think and perceive, and therefore our capacity to make sense of *future* experience and events."

(Moore, 2012. P.7. Italics original)

This also reflects Heidegger's central argument that 'being is time' (Gadamer, 1979; Warnke, 1987); a being exists in a given point in time and is defined as

much by its past and future as by its present. Therefore, a training experience will only be experienced as satisfactory in so much as it relates to what the being understands as its future; what it is *becoming*. For Judy the experience of training in SFBT was less satisfactory because she was not *becoming* the type of nurse to whom SFBT would be a relevant skill and knowledge base. Dawn and Lesley, on the other hand, were clearly *becoming* the type of nurse to whom these skills and knowledge would be highly useful. This, then, develops the arguments put forward by the early SF Nurse theorists (Webster, 1990; Montgomery and Webster, 1994; Hillyer, 1996) that SFBT offered a framework for practice that was congruent with nursing values. It can be seen that SFBT reflects the values of *some* nursing paradigms, but does not necessarily reflect the values of *all* nursing models; therefore, the experience of nurses undertaking training in SFBT is related to the extent to which the principles and practice of SFBT reflect the values of the individual nurse's internalised paradigm of nursing.

Chapter 11: Issues of Quality

11.1 Chapter Overview

In this chapter I shall explore the quality issues relating to the believability of the study. I shall begin by discussing the background to quality issues in qualitative research generally, before discussing the particular issues of practitioner research. I will examine this work in relation to some of the benchmark practices for managing the quality of qualitative research, and I shall then briefly explore some of the lines of thought that were abandoned in order to maintain the quality of the work. Finally I will review my research diaries, highlighting the development of my thinking and focus of interest across the period of the research project.

11.2 Background

In any research project the strength of the study lies in the quality of the research undertaken. Traditionally referred to, within the quantitative paradigm, as validity, generalisability and reliability; within the qualitative paradigm these issues are sometimes addressed in the same terms (Lewis, 2009) or, more commonly, as credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985), validity and relevance (Mays and Pope, 2000) or trustworthiness (Shenton, 2004). Rolfe (2006) divides those who undertake qualitative research into three groups: those who would apply the same quality measures as are utilised in quantitative research, those who would apply a different set of measures specific to qualitative research, and those “who question the appropriateness of any predetermined criteria for judging qualitative research” (p. 304). He notes that the second position has generated the most discussion and has produced a variety of frameworks for controlling the

quality of qualitative research. Rolfe, however, argues that, in the absence of a cohesive qualitative paradigm, there can be little merit in proposing a single, unified model for assessing the quality of studies. He concludes,

“We need either to acknowledge that the commonly perceived quantitative–qualitative dichotomy is in fact a continuum which requires a continuum of quality criteria, or to recognize that each study is individual and unique, and that the task of producing frameworks and predetermined criteria for assessing the quality of research studies is futile.”

(Rolfe, 2006. p.304)

This second option reflects the position taken by Sandelowski (1993), who argues that the notion of an external, observable, repeatable reality is contradictory to the naturalistic / interpretative paradigm at the heart of qualitative research. She acknowledges the work of Elliot Mishler in proposing that the evaluation of the quality of a qualitative project is essentially a matter of individual judgement,

“whereby skilled researchers use their tacit understanding of actual, situated practices in their fields of inquiry to do their own work, to make claims for it, and to evaluate the work of others.”

(Sandelowski, 1993. P. 2)

In essence she is arguing that no *external* process or structure can guarantee the quality of a project, but that the quality of the study lies *within* the work and is evaluated, individually, by each reader, each time they read it. This is, of course, congruent with Gadamer’s position that a critical understanding of a work is achieved through a meaningful engagement with the work itself, and not through the application of any particular method to replace that individual

engagement (1979. p. 447). On the other hand, while it is the reader who must engage with *this* particular piece of work and, through that engagement, evaluate the trustworthiness of the endeavour, that process of evaluation may be assisted by knowledge of some of the steps I have undertaken to 'control the thrall of my prejudicial expectations'.

11.3 Validity / Believability

Robson (2002, p173) summarises Ahern's work on reflexive bracketing and highlights ten points to be considered in dealing with potential researcher bias. Several of Ahern's points have some significance here, for example, "write down your personal issues in undertaking this research", "clarify your personal value system" and "consider where the power is held in relation to your research project", and it is hoped that these principles are evident in this work; however, the context of these points is conveyed in other suggestions, such as "recognise feelings that could indicate a lack of neutrality" and "on occasion, stand back and ask yourself if you are 'going native'". Therefore, this has limited relevance for the present study in that there is no attempt being made here to bracket my own experience and prejudicial ideas; rather, they are the basis of my analysis and so, the challenge is to make these clear to the reader. Robson goes on to review Padgett's work in developing strategies to counter threats to validity inherent in practitioner research. In doing this he highlights a number of strategies including triangulation, peer debriefing, member checking, negative case analysis and audit trail (Robson, 2002, p174).

11.3.1 Triangulation

Triangulation has traditionally been used to compare and contrast different types of data, and data gathered from different subjects, within a research study

(Torrance, 2012). In this case data was gathered from an initial descriptive interview and from a later, more focused interview. In the first interviews data was analysed using a thematic / paradigmatic analysis, while in the later interviews data was analysed using a hermeneutic technique. In addition, an earlier set of interviews (the Pilot Study) can be compared with the data from the Stage I set of interviews here. The data from both interviews, and the differing styles of analysis thereof, can be (and has been) examined for inconsistencies. While not undertaken as 'triangulation' *per se*, this is an essential part of the hermeneutic circle described by Gadamer, wherein,

"we must understand the whole in terms of the detail and the detail in terms of the whole ... the parts, that are determined by the whole, themselves also determine this whole."

(Gadamer, 1979. pp.258 / 259)

Thus, the data generated from different forms of interview, occurring over a prolonged period of time, are triangulated into a 'whole understanding' which is supported by each and all of its parts, and no part compromises the whole understanding.

11.3.2 Peer de-briefing

Shenton (2004) argues that both 'peer scrutiny' and 'debriefing sessions' involving the researcher's supervision team help to promote confidence in the truthfulness of qualitative research. This has been a key element of this project. I have had regular and prolonged contact with my lead supervisor, and ongoing appraisal by the supervision team as a whole. I have also presented aspects of my work at a number of fora and conferences including departmental academic 'share' sessions and an international conference on solution focused thinking.

This last event was particularly useful in that it generated further discussion with experienced academic colleagues and helped me to clarify my understanding of the (at times) confusing relationships between the work of Brentano, Husserl, Heidegger and Gadamer, specifically in relation to the use of bracketing and the attempt to transcend self.

11.3.3 Member checking

Member checking involves asking the participant to read the transcript of the interview and/or the analysis of the transcript in order to review the accuracy of the recording (Houghton et al, 2013). In Stage I of the project I asked each of the participants to review the transcript of the interview following analysis of the text using the adapted seven-step formulated meaning model (Colaizzi, 1978). Houghton et al (2013) discuss the potential challenges around when to employ member checking in the research process, suggesting that this is best utilised after transcription but before analysis (p14); however, in this instance, I wished to ensure that *my* understanding was that which the participant had *meant* for me to understand and, therefore, participants were invited to review their interview and any changes to interpretation they felt were necessary would be accepted. In the event no changes were required. In Stage II a different policy was employed. As the interviews had been audio recorded (they had, of course, also been audio recorded in Stage I) there was a permanent record of what had been said, and so the accuracy of the transcript was not in doubt; with regard to the *interpretation* of what was said, McConnell-Henry et al (2011) argue that member checking is not congruent with the philosophy of Heideggerian (or Gadamerian) phenomenology. They posit that, at the interpretive stage, where 'multiple truths' exist, the notion of the 'right' interpretation is redundant. This clearly reflects Gadamer's position that

"To interpret means precisely to use one's own
preconceptions so that the meaning of the text can really be

made to speak for us ... Every interpretation has to adapt itself to the hermeneutic situation to which it belongs."

(Gadamer, 1979. p.358)

In other words, my interpretation of the texts is *an* interpretation, and the salient point is not how 'correct' it is but how 'believable' it is. Any other interpretation, including one derived from member checking, would be just that: another interpretation. Therefore, although member checking was utilised in Stage I to check the accuracy of my understanding of *what happened* (i.e. the participant's account of events), it was not utilised in Stage II as this represented *my understanding of why it happened*. Arguably, had there been a further round of interviews with these three participants, it may have been useful to check how closely my understanding matched the participant's understanding (a means of strengthening the fusion of horizons); however, eventually I have to own my own understanding and interpretation.

11.3.4 Negative case analysis

Robson (2002) argues that negative case analysis is a useful tool for combating researcher bias. While I would argue that 'negative case' is only an appropriate term where one is attempting to prove a point (or support a hypothesis), the practice of analysing 'atypical cases' can be seen in my analysis of Judy's text. Clearly, I hope, my intention was not to demonstrate that training in SFBT had a universally positive impact on the lives of nurses who had completed the training, but rather to explore what that impact was, and why that might be the case. Therefore, the exploration of Judy's text not only gave me an understanding of her experience, but in an iterative fashion, gave me a better understanding of the experience of her two colleagues.

11.3.5 Audit trail

In arguing that the ultimate responsibility for evaluating the quality of a piece of research lies with the reader of the work, i.e. that *I* (the author/researcher) cannot tell *you* (the reader) that this is a quality piece of research, you have to decide that yourself (in Gadamerian terms, 'you will come to an understanding of my understanding'), Rolfe (2006) emphasises the central importance of the audit trail in enabling the reader to come to that decision. He states (p.309) that the researcher must demonstrate a continuing critical appraisal of their work and their developing understanding of it. Similarly, Lewis (2009, p.12) argues that a clear audit trail is often "the only item that will persuade qualitative researchers that the research is valid." A clear audit trail in relation to the data content is provided by the appendices, and a figurative depiction of the data collection and analysis process can be seen in Table 4 below.

Stage 1	75 potential participants identified and contacted by email.
Stage 2	31 (41%) participants agree to be interviewed.
Stage 3	20 interviews (64%) actually carried out (no internal factors involved in determining inclusion).
Stage 4	Transcript of interviews.
Stage 5	Analysis of transcripts using adaption Colaizzi's (1978) seven-step formulated meaning model.
Stage 6	Member checking
Stage 7	Analysis of data using thematic, paradigmatic and typological approaches.
Stage 8	4 participants identified from typological analysis and requested to participate in Stage II.
Stage 9	3 participants (75%) agree and interviews carried out.
Stage 10	Transcript of interviews.
Stage 11	Analysis of individual texts using Gadamer's hermeneutic circle.
Stage 12	Analysis of my understanding of collective texts in relation to each other: fusion of horizons.
Stage 13	Exploration of my understanding of participants experience in relation to the relevant literature.
Stage 14	Synthesis of my understanding in response to the Research Question.

Table 4: Process of data collection and analysis.

11.4 Holzwege and 'Red Herrings'.

In his discussion of the audit trail, Rolfe (2006) states that the researcher must be able to show

"the *actual* course of the research process rather than the *idealised* version that the reader is usually presented with".

(p.309. Italics in original)

Much of this 'actual' course of my research has been shown in the preceding chapters; however, there were a number of avenues of enquiry which although appearing worthy of investigation, produced little of real outcome. Krell (1993) makes reference to Heidegger's collection of essays, "Holzwege", published in 1950. In this, Heidegger explains the Holzwege of the title as being 'woodpaths though the forest';

"Each goes its peculiar way, but in the same forest. Often it seems as though one were identical to another. Yet it only seems so. Woodcutters and foresters are familiar with these paths. They know what it means to be on a woodpath."

(Heidegger, 1950. Cited in Krell, 1993. p.34)

The inference is that these paths appear to go nowhere; but to the initiated they always lead somewhere, but where they go cannot be predicted until one knows the path. This seemed to me similar to what in SFBT are called 'red herrings'; an ostensibly interesting path of discussion which is actually a distraction from the task of co-constructing solutions. Although there are some differences; red herrings are a distraction, while Holzwege help define the geography of the

forest, they both seemed to me to suggest the quality of some of these abandoned avenues of enquiry. Both terms have a quality of being a distraction from the task of 'getting to the nub of the matter' and yet add to the richness and texture of the understanding surrounding that task. The most obvious of these was my early intention to parse sections of transcript into poetic stanzas (see Chapter Five), a technique which was intended to convey the intense, detailed meaning of the participant's narrative in an accessible format. Miles and Huberman (1994), in considering the use of this approach by Richardson, argue that,

"You have to treat the data set – and the person it came from – seriously because a "poem" is something that you engage with at a deep level. It is not just a figurative transposition, but an emotional statement as well"

(Miles and Huberman, 1994. p. 110)

While I would not disagree with Miles and Huberman on this general point, in the specific context of my analysis I felt that this was 'a step too far'. In deciding to utilise Colaizzi's (1978) model to formulate meaning from significant portions of text, I came to the conclusion that parsing the text into poetic stanzas first-of-all would create an artificial barrier between me and the text; the opposite to what I had initially intended. While this may have been the most obvious red herring, there were a number of others.

11.4.1 The gallery of experience

In the early stages of my research I had the idea of presenting the findings of the project within the metaphor of an art-gallery. This seemed an attractive structure in that I could have the 'foundations' (the chapters on design and methodology) at the lowest level with the findings from Stage I presented in a

series of iterative galleries on the first floor, leading to individual texts on the second floor and a fusion of horizons on the upper-most floor. While this struck me as a potentially effective way of demonstrating the inter-relatedness of all of the parts, to the whole, of the project by the end of Stage I it had become apparent to me that the convenience of this presentation form was in danger of patterning what I focused on in order that it fit into the pre-ordained structure. While recognising the strengths of the idea in relation to presenting the data and analysis related to Stage I, I abandoned the idea of the gallery of experience as being part of the overall project.

11.4.2 SFBT as a hermeneutic endeavour

Having utilised a SF design in Stage I of my study, and having been led, in my exploration for a compatible recognised framework, to Gadamer's phenomenological hermeneutics in Stage II, by the midpoint of Stage II I was becoming interested in the potential to see SF as a hermeneutic exercise. I reasoned that, as a SFBT practitioner, I utilised my prejudicial knowledge (e.g. of the process of solution building) to engage with the client in a hermeneutic circle in which we explored 'what was working' in an iterative fashion, moving from the grand scale of the 'positive future scenario' to the minutia of specific examples of 'exceptions', until we reached a fusion of horizons in which we shared a co-constructed awareness of positive change. While this remains an area of interest to me, I came to recognise that line of thinking was tangential to my project and, therefore, have placed it on a 'back-burner', so to speak.

11.4.3 SFBT and Zen

During the early stages of drafting the written thesis I became aware of, what I saw as, parallels between some of the ways in which Steve De Shazer had

presented his thinking on SFBT, and the cultural influence of Zen Buddhism. I began to explore this in a little more depth and drafted an opening paragraph to a more detailed discussion (as I imagined it would become). I wrote,

“I have always been struck by the analogy of this with the zen concept of dharma heir, in which the ‘truth’ of Zen understanding (dharma) is passed from Master to pupil, generation to generation, thus legitimising each successive generations teaching. Arguably, De Shazer presented himself (and has been represented since) as a dharma heir of Milton Erickson, via John Weakland. This Zen analogy can also be seen in the apparent depiction of De Shazer, on the cover of his 1994 book, ‘Words were originally magic’, in the style of Ekaku’s Eighteenth Century scroll calligraphy of Bodhidharma, the first Chinese Patriarch of Zen.” [See figure. 1]



Figure 1. Comparison of depictions of Bodhidharma (L) and Steve De Shazer (R).

In order to develop this line of thought further, I consulted some of my SF colleagues via an online forum. I asked them to tell me what they saw on the cover of 'Words Were Originally Magic'; the first two people to respond sent me a scanned image of the cover (a very SF inspired response), four people responded with variations on the message 'a bald oriental-looking gentleman'. No-one, apparently, thought the image represented Steve De Shazer, and thus, my argument began to crumble. Accepting that this was not a central aspect of my thesis, this too was set aside.

11.5 Reflexive Diary

Rolfe (2006) has argued that all good qualitative research should include the use of a reflexive research diary. I have utilised a number of such diaries over the period of this project; often taking the form of a dialogue with myself (on other occasions simply noting a new idea), these entries can be seen to mirror the development of my thinking about the study, the nature of PhD research, and the development of my thesis.

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11.5.1 Early Stages

In the very early stages of my research I was focused on the literature review as it pertained to SFBT. I had conceived of a 'funnel approach' in which I began at a *macro* level and successively focused my attention on increasingly *micro* levels of literature. I depicted this as shown below.

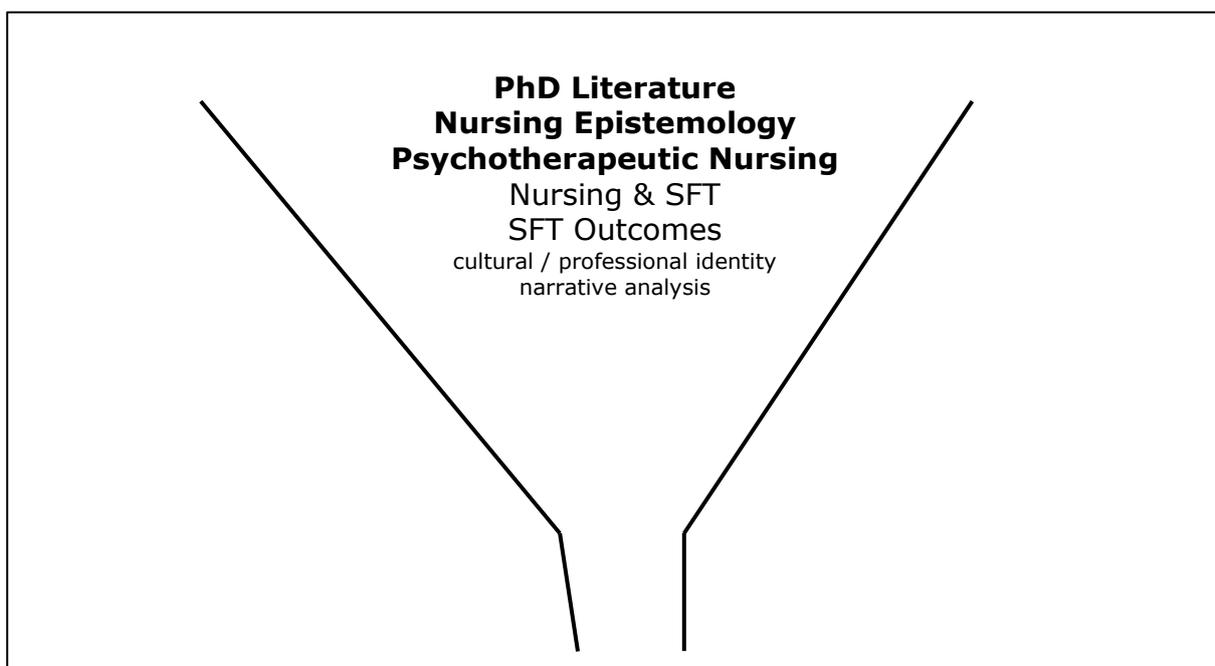


Figure 2: Extract from Research Diary dated 18/03/09.

I recorded at this time that,

“the general area of my research is Nursing, and in particular psychotherapeutic nursing. The focus is on Nursing and SFBT. The Research Question is on the impact of training on nurses – especially their professional / cultural identity. However, this will probably change over time – I may well spend the next year narrowing this down.”

(Research Diary: 18/03/09)

I can see, from looking back at this, that although I had an ‘outline plan’ of how to proceed, I was lacking a clear understanding of what I was really doing. In an attempt to orientate myself (and on the advice of some very helpful colleagues), I began to read around the subject of ‘carrying out a PhD research project’ (Holloway and Walker, 2000; Rugg and Petre, 2004; Wellington et al, 2005), reviewing texts as I went along; for example, on Rugg and Petre (2004),

“This is very helpful. Less a ‘font of knowledge’ (as Wellington et al was) as a ‘font of wisdom’. Anecdotal accounts based on author’s experience. A softer approach, supports and confirms Wellington et al.”

(Research Diary: 28/04/09)

From this reading, it came as something of a shock to me when I realised that I was not going to spend the next few years studying SFBT, but rather I was going to be studying ‘research’ itself.

"Eureka moment! This isn't about SFT, it's about research. The 'topic' might be SFT, but the 'subject' being studied is research – I'm going to have to learn how to do a research study and then demonstrate I know how to do it. How could I have missed that?"

(Research Diary: 11/05/09)

At this point, I think, I came to have a clearer understanding of what the project was about, and what I had undertaken. Although I would say that I had a 'surface understanding' of the nature of the project, it was at this point that I realised that I did not actually know *how* to do it. I had, in a sense, an understanding of each of the stages, the parts if you will, but no clear understanding of how they came together, the whole.

By the end of 2009 I was still experimenting with discrete ideas and exploring how they (if they) interconnected with each other.

"Given that sft was devised as a process of 'finding out what works and doing more of it', the therapeutic approach that was derived from that process can be seen as a synthesis of existing therapeutic techniques which have been demonstrated to be clinically effective in bringing about positive change in [a] focused manner. Put another way; sft is a structured distillation of 'good practice' that has been demonstrated, through clinical research outcome studies, to be effective. More simply; the practice of sft is the application of evidence based clinical wisdom."

(Research Diary: 28/10/09)

These thoughts were something of an exploration into SFBT and an interest within the School of Nursing and Midwifery, at Robert Gordon University, at that time, in the notion of 'Clinical Wisdom'. In experimenting with these ideas I would argue that I was engaging in a hermeneutic dialogue, testing out new

relationships and ideas, observing which of them withstood the scrutiny of critical conversation.

11.5.2 Middle Stages

By the end of 2011, having completed most of Stage I, I had developed a clearer understanding of what I was doing and was asking more specific questions of myself.

“Realisation – it’s OK to bring in other narratives to support ‘my’ narrative. Fraser (2004, p183) talks about ‘secondary texts’; so that means I can analyse texts such as DeShazer, and the Thistle narratives. It might be interesting to try the UKASFP list for stories.”

(Research Diary: 19/10/11)

Recognising that I now had a narrative of my own to tell (‘my’ narrative), being the synthesis of the narratives I had been given by the 20 participants in Stage I. This was my story, based on the stories I had been told, and I recognised that, once told, it would become *your story* to tell; the challenge for me was how to tell my story as honestly as I could. A major breakthrough occurred for me following one of many conversations with my colleague, Dr Andy McKie, in which he had alluded to his utilisation of the work of Paul Ricoeur.

“Reading Andy’s thesis – he explores his narratives through ‘Ricoeur’s Hermeneutic’. Important – his description of phenomenology is Heideggerian; however, he’s using a hermeneutic phenomenology (Ricoeur’s) to analyse those narratives. The development of phenomenological thinking. I will be able to use Gadamer as a window through which to

view the Heideggerian data [narratives] I have. Eureka moment!!!”

(Research Diary: 19/12/11)

It was at this moment, I think, that I not only developed a clear idea of what it was I intended to do with the project, but that I made the shift from seeing it as a SFBT based project to seeing it as a philosophical project. Given that I had begun to realise this two-and-a-half-years earlier (see above), I would see this as the completion of one stage of my understanding, and the beginning of a new stage of understanding. However, even with this *new understanding* I continued to perceive links between SF thinking and that which I was discovering in the world of hermeneutics.

“Are there links between SF and Foucault’s Negative Hermeneutic?

‘It is no longer an identity we need to recover (a secret tragic identity) but a difference ... In short, the movement has not been beyond hermeneutics and repression but beyond a hermeneutics of identity (a positive tragic hermeneutics) to a hermeneutics of difference (a negative hermeneutics of refusal).’ (Caputo, 2000. p34)

Is this an interest in ‘what you don’t want to change’ – what you want to keep (Lipchick, 2002) – SF as a hermeneutic of difference?”

(Research Diary: 09/02/12)

In re-reading these reflections I am still aware of a sense of something to be explored further, but recognise (as discussed above) that that exploration lies outside the remit of this project.

11.5.3 Later stages

In the later stages of my research my attention returned to, among other things, the basis of my thesis and the research question. I suspect that in order to reassure myself that I was still focusing on the research question, I came back to some of my earliest thinking on the project, checking that my current thinking was still appropriate in the context of the aims of the project. I would argue that this iterative return to the beginning in the context of the (near) end is appropriate, both in a hermeneutic sense and in the context of good qualitative research (Rolfe, 2006). Some of the questions I was asking myself at this point strike me as some of the most basic questions I could ask (see Figure 3 below).

Other issues that confronted me at this time surrounded how to deal respectfully with the data I had been given by the participants in Stage II. I recalled an early reading of Gadamer, from about a year previously, in which I had read with interest his discussion on Helmholtz and Bildung (Gadamer, 1979. p. 16/17). Here, Gadamer relates Bildung to *tactfulness*, defending the argument posited by Helmholtz that tact enables one to 'pass over' something in such a way that it is observed with grace and finesse, thus avoiding the indiscreet and invasive intrusion into the other's personal domain.

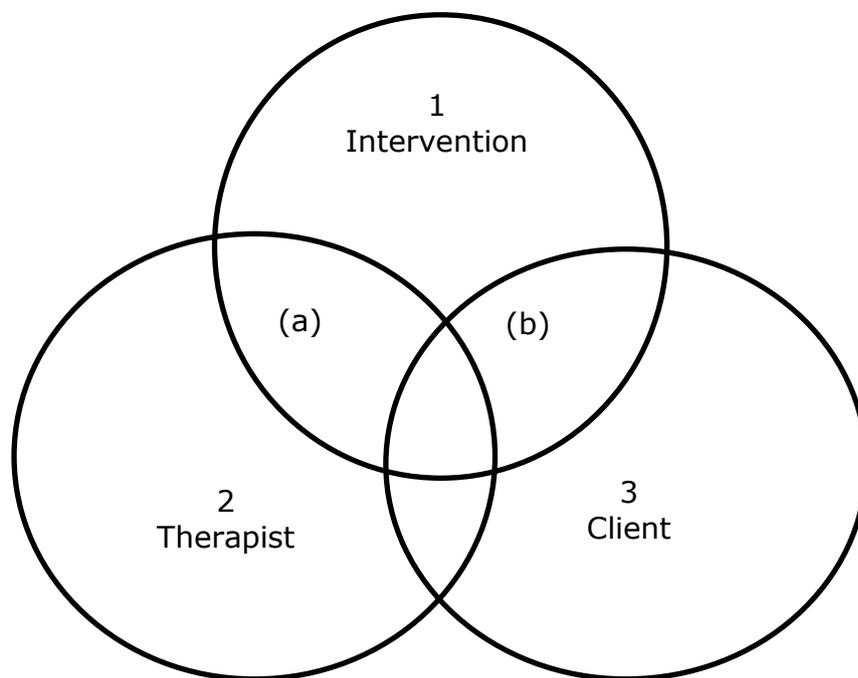
"How can I be the 'best audience' for the participant?
-Listen to what she's telling me.
Recognise she's being the best narrator that she can be –
what does she need from me?
-Work with the original transcript. What are her primary
answers?
-What are the themes of our conversation? What informs
these themes?
-Stay text focused – avoid 'red herrings'.
Intuitive interpretation must be based on text. Interpret what
she means, not why she means it.
Own my interpretation!"

(Research Diary: 15/12/12)

Q: What is the basis of the argument (thesis) I'm putting forward?

The importance and relevance of therapist & client characteristics in outcome research is largely overlooked. Relevance is recognised in terms of EB [evidence based] Psychological Intervention reviews & recommendations, but research continues to focus on intervention as though an independent variable.

Interventions are delivered by therapists to clients.



Current research focuses on 1 in relation to 3.

However 1 is actualised by 2.

Training in 1 has impact on 2 (a)

Delivery of 1 has impact on 3 (b)

Current research focuses on (b); however 2 must be trained in 1 before (b) can occur. This study explores (a).

Figure 3: Extract from Research Diary dated 03/09/12

The final stages of my journal reflect the construction of the formal thesis, bringing together the various 'building blocks' of my argument and structuring them into a cohesive whole (figure 4). Some parts, even at this stage, remained speculative (specifically, the possibility of linking SF thinking with Zen Buddhism; a prospect that, while appealing to me, would have been an indulgence), however, it can be seen that the overall structure of the thesis was becoming clear at this time.

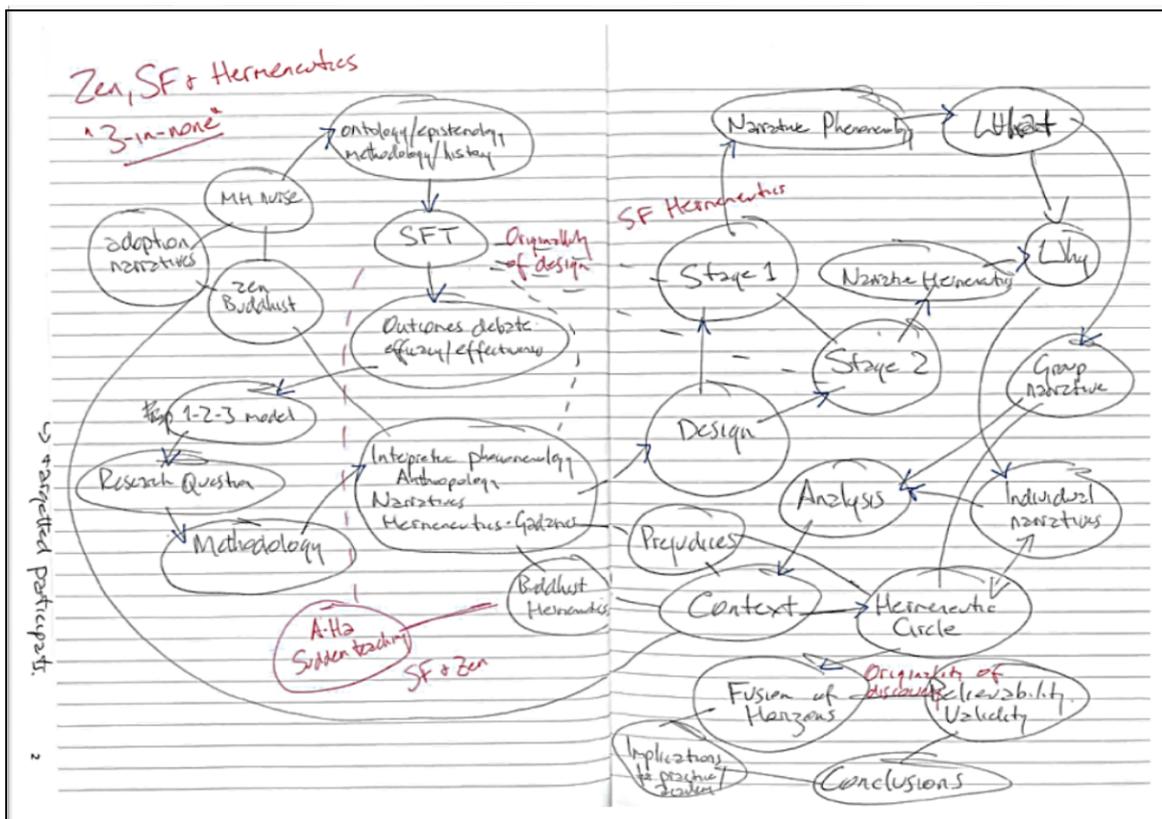


Figure 4: Extract from Research Diary dated 22/04/13

In presenting these extracts from my Research Diary, and in discussing the various strategies one might employ to determine validity in qualitative research, it is not my intention to *demonstrate the validity* of the research project I have undertaken; rather, these are presented as supporting evidence to help the reader judge how *believable* is the story I have told you. Based on that judgement you will then recount a narrative; your story of my story of the stories of nurses who have undertaken training in solution focused brief therapy.

Chapter 12: Conclusions

12.1 Chapter Overview

In this chapter I shall conclude my thesis that the experience of nurses training in SFBT is dependent upon the paradigm of nursing from which they practice and expect to develop. Returning to the question asked at the outset of the project, a succinct response, summarising the findings of the study, will be offered. Areas for further research will be suggested, and the originality of the research will be discussed. Finally, implications for future practice, clinical and academic, will be discussed.

12.2 Conclusions

In this thesis I have asked the question, "What is the experience of nurses who have undertaken training in solution focused brief therapy?" It can be seen that for many of the participants the experience was a profound one, SFBT provided a practice paradigm which enabled them to provide the type of co-operative, egalitarian and concordant care they had been unable to provide in their previous practice. An analysis of the texts derived from the interviews conducted in Stage I suggests that many of these participants found their previous practice largely ineffective in helping clients achieve their goals, lacking in a coherent framework, disempowering to clients, and it didn't fit with their personal and professional world view. This last point resulted in many of them feeling jaded, lacking enthusiasm and dissatisfied with professional identity, for some this sense was so all pervading that they only became aware of it once they had experienced the renewed enthusiasm and satisfaction that they found in SFBT practice. Their experience was that they found they were able to genuinely trust clients with their own wellbeing, I have suggested that this is a

singularly unusual experience in mental health care, but one that is necessary if the practitioner is to truly empower the client to take control of their own recovery. They also found that SFBT provided them with a defined framework for practice, focusing their attention on the client's strengths and assets as opposed to their faults and deficits, and providing them with a framework more in keeping with their own ontological perspective. They also found their practice had become much more successful in terms of actually helping clients. Perhaps of greatest significance from the practitioner's point of view, training in SFBT enabled a group of disenfranchised NHS practitioners, disengaged with the dominant bio-medical and psychological models of practice and the nursing models that supported them, to deliver an alternative model of care in which they became successful, engaged practitioners reflecting the highest standards of contemporary mental health policy and legislation.

I have argued here that training in SFBT provides nurses with an alternative model of practice to the dominant 'medical' and 'psychological' models of contemporary practice. The experiences of (most of) the participants reflect the claims made by the early literature in relation to SFBT and nursing, that SFBT is an effective intervention, that it reflects (some of) the values of nursing, and that nurses can easily incorporate SFBT into their practice. Of note, the most common reason given by participants for not being highly satisfied with the training experience was an inability to incorporate it into clinical practice. Some of the reasons for this were explored in Stage II of the project.

In order to understand something of 'why' they may have had that experience, Stage II undertook a hermeneutic exploration of the experience of three particular participants. An initial impression that the nature of the participant's experience might be related to the type of environment in which they practise proved to be unsupported; two participants found their experience highly positive regardless of whether they worked in an individual or team setting, and the third participant found her experience significantly less satisfactory, again regardless of the type of setting she was employed in. However, a detailed, in-

depth analysis of the texts of the interviews conducted with all three participants, utilising the hermeneutic phenomenological model described by Hans-Georg Gadamer, suggests to me that the nature of the nurses' experience was related to the paradigm of nursing each nurse used to inform her practice. Although this understanding was almost always unspoken and implicit, my interpretation of the texts suggests that each of the three nurses had a clear paradigmatic understanding of what it was to be a nurse, and that this understanding informed the direction of her professional development and, therefore, the relevance of SFBT to that development. Where the nurse operated within a dynamic, interpersonal paradigm her satisfaction with the experience of training in SFBT was greater than where she operated within an assessment of needs / delivery of care paradigm.

This, then, confirms my initial formulation, based upon my prejudicial assumptions that those nurses who found SFBT useful would reflect a dissonance between their ontology and the epistemology and / or methodology of contemporary mental health nursing practice. It can be argued that the dominant model of nursing in contemporary practice (Roper, Logan and Tierney's [1996] model) reflects a positivist paradigm in which Activities of Daily Living can be assessed and packages of care can then be delivered to meet the identified needs and thereby the patient is helped; conversely, the interpersonal model (epitomised by Altschul, 1972) reflects a more constructivist paradigm in which reality is created through shared understanding, and meaning is co-constructed between the nurse and client. Therefore training in SFBT (coming from within the constructivist school of thought) provides those nurses, whose ontological perspective reflects those values, a valid alternative epistemological and methodological basis for their practice.

This understanding, then, casts new light on the claim made in the SF nursing literature that SFBT is congruent with nursing values (Webster, 1990; Montgomery and Webster, 1994; Hillyer, 1996; Bowles et al, 2001). It can be seen from this research that SFBT is congruent with *some nursing values*, but is

not congruent with *all* nursing values; thereby adding to our understanding of the relationship between SFBT and nursing practice.

12.3 Further Research

It is important to remember that the results of this study pertain only to the twenty participants in Stage I, and to the three participants in Stage II. Further research is therefore required in order to deepen our understanding of the results of this study. Firstly, it would be of value to test whether the findings of Stage II are replicated in interviews with other participants in Stage I. Would those participants who, in Stage I, reported satisfaction with their SFBT training experience describe a nursing paradigm similar to that described by Dawn and Lesley, and would those who reported a less satisfactory training experience describe a similar paradigm to that described by Judy? While there is evidence in the Stage I narratives to suggest that this may well be the case, further research is required to support that assumption. With hindsight it would have been useful to have included more Stage I participants in Stage II, however this was not apparent at that time. It can be seen that the findings of Stage II allow for a hypothesis to be generated, and further research is now required to test that hypothesis. If the findings of the study with Dawn, Judy and Lesley held true for the other seventeen participants, it would then be interesting to test them with a wider group of practitioners; do nurses who practice in SFBT operate within a different nursing paradigm (similar to that described here) to nurses who do not practice SFBT?

A second direction for future research would be to explore the potential for testing prospective students for selection onto a SFBT training course. Would prospective students whose practice paradigm, or personal ontological outlook, was congruent with the SF metaparadigm have better training outcomes than prospective students who were less SF oriented in their outlook; would they go

on to practice in a SF manner more than their colleagues? Further research is also required to develop the argument made at the outset of this thesis; if training in SFBT provides a very positive experience for some nurses, as described here, does that experience contribute to changes in clinical outcomes experienced by clients of those nurses?

Finally, further research and debate is required to test whether SF thinking can provide a viable methodological basis for conducting research, as has been argued here. Can a methodology utilising the principles described in Chapter Three, where the 'problem' is the Research Question itself, and the 'solution' is the response to that question, make a worthwhile contribution to the field of research; and, if so, how?

12.4 Originality

There are several original elements to this research project. From a design perspective, the SF methodology utilised in Stage I is an original contribution to research design. Starting from the premise that SF reflected a mode of thought, rather than just a therapeutic technique, I have utilised eight principles of SF thinking to develop a uniquely SF research methodology; as far as I am aware, this has never been done before. From this research, it can be seen that a SF methodology is congruent with the hermeneutic methodology developed by Gadamer and, I would argue, that SF thinking provides a framework within which to operationalise Gadamer's hermeneutic without becoming entrapped in the restrictions of a definitive *method*.

Secondly, this research develops our understanding of the links between SFBT and Nursing. As discussed above, for almost 25 years it has been accepted within the SF literature specific to nursing that SFBT and nursing share common

values and assumptions. As far as I am aware, this is the first study to begin to challenge that assertion and to provide a research base for it, and in finding it only partly sustainable this research has made an original contribution to the body of SF knowledge and understanding.

Third, this research defines a metaparadigm of SF practice. While the concept of a metaparadigm of practice is not new, this research builds on the existing work in this field and applies it to the practice of SF for the first time. This, then, is an original contribution to the body of knowledge relating to SF practice; further discussion within the SF community will determine whether it has value for our understanding and practice in SF interactions.

Finally, this research provides an original insight and understanding of the experience of nurses who undertake training in SFBT. Where previous studies have attempted to explore the impact that training nurses in SFBT has on the clients they work with, this research argues that the relationship between training and clinical outcomes is more complex than these studies assume. It has shown that the nurses' experience of training is dependent on the paradigm of nursing within which they practice, and that for some, training in SFBT provides a transformative experience, greatly enhancing their professional identity and their ability to help clients achieve (and maintain) their own personal health goals.

12.5 Implications

Arguably, every research thesis implicitly ends with the question, 'So what?' What are the implications of the study for practice and / or academia? I would argue that the implications of this research thesis are fourfold. First of all, it suggests that training in SFBT can have a profound impact on the practice of

nurses. I would suggest that there are a significant number of practitioners for whom the dominant bio-medical and psychological paradigms, and the corresponding models of nursing practice, are not congruent with their ontological perspective, resulting in these practitioners becoming disenfranchised and disillusioned with their role. Training in, and subsequently practising SFBT not only allows these practitioners to reengage with contemporary health care, but enables them to achieve improved clinical outcomes over shorter periods of client contact. This has obvious implications for enabling stretched NHS services to make better use of clinical staff resources in relation to both clinical waiting times and the need for collaborative, compassionate and empowering nursing care.

It is also suggested that practising SFBT enables nurses to reclaim ownership of their practice. I would argue that SF practice provides the potential for nurses to break the pattern of professional dominance exerted by medicine and psychology, and to assert their right to be nurses. Challenged to 'come down off the fence', I would suggest that the dominant models of nursing (such as the Roper-Logan-Tierney model) offer a pragmatic response to the double-bind of medical/psychological hegemony – it is what 'nurses do, because they have to'. Nurses therefore engage in a series of activities which ultimately are of greater service to the dominant health care disciplines than they are to the patients/clients we seek to help, while telling ourselves the opposite is true. If nurses are to develop our potential to engage in genuine interactions with the people we nurse, we must break out of this restrictive relationship and develop a practise that complements, rather than serves, that of other disciplines. Practising SFBT can, arguably, not only empower the clients we work with, but the nurses who practise it.

Secondly, we may be able to assess the aptitude for SF practice in prospective students before they commence training. The use of a SF assessment tool (Smock, McCollom and Stevenson [2010] have developed one such example, which they term the *solution building inventory*, Grant [2011] has developed

another, termed the *solution focused inventory*) would enable screening of students for inclusion in a training course. This would not only help direct, scarce resources within the clinical organisation towards those clinical staff identified as most likely to complete the training and utilise the skills thereafter in clinical practice, but it could also facilitate a more individualised training programme for staff within an organisation, where training is matched to practitioners' outlook and likely future practice. This would not only avoid the rather 'scatter-gun' approach adopted towards training by many organisations, but would provide recognition and validation of an alternative clinical pathway for those practitioners whose ontological perspective is not congruent with the dominant 'assessment / delivery' model of nursing in contemporary healthcare.

Thirdly, this research suggests that a SF methodology may exist and may be of use to the academic community. As discussed above, further research and debate within academia is required before a decision is reached as to whether SF Research represents a new research paradigm in the same sense as feminist, ethnic, cultural and Marxist research represented a paradigm shift some thirty years ago (Denzin and Lincoln, 1998), or whether it sits within some other existing paradigm. For the moment, this research may serve as a point of departure for that debate.

Finally, this research has implications for the field of SF practice, as a whole. The development of a metaparadigm of SF practice helps to define and delineate the scope and field of SF practice, without limiting either to one specific domain of practice. This may have relevance for those within the SF community (although given the traditional avoidance of theoretical discussion, this may be a limited group within that community), but it may also have relevance for those outside the SF community, and for communication between the two. As discussed in Chapter Three, SF practitioners have tended to have difficulty in explaining 'what it is we do' to non-SF practitioners in anything other than rather protracted anecdotal terms; the development of an explicit SF metaparadigm may help focus these discussions on what it is that defines SF practice.

Whether the implications that this research raises are developed is, of course, another story.

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Appendices



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

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Accepted for publication: 3 August

2009

doi: 10.1111/j.1365-2850.2009.01492.x

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 emplotment, 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

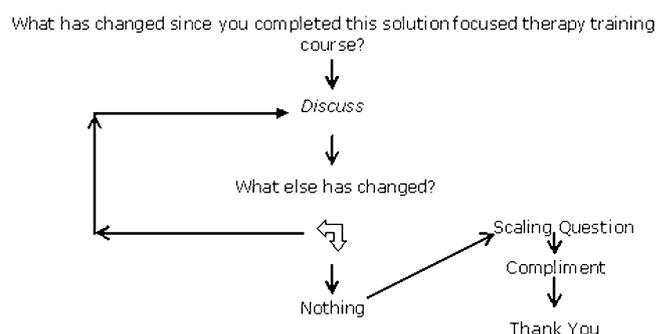


Figure 1
Schematic representation of the interview process

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 partici-

pants 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 led 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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Appendix 2

Interview Schedule / Thematic Guide.

Mirroring the constructivist perspective of solution focused therapy, the research interview will adopt a similar theoretical stance and seek to engage with the interviewees in co-constructing a narrative account of 'changes' which the interviewee has experienced (in the specific context of the course and their clinical practice) since undertaking the course.

The interview will adopt a *solution focused* approach reflecting the European Brief Therapy Association (EBTA) research definition for a solution focused therapy interview. As a minimum, these will include:

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

In general terms the interviewer will adopt a respectful, non-blaming and cooperative stance, working from within the interviewees' frame of reference. The interviewer will have to adjust the exact wording and (where applicable) timing of these elements, as described in the following sections of this interview protocol.

"The interviewer asks 'what has changed?' at the beginning of the interview and follows up on it"

The interviewer asks "what has changed (since you commenced this solution focused therapy training course)?"

This question should be the opening of the interview, and therefore should be asked *within the first two minutes of the session*.

Follow up questions serve the purpose of getting a description in specific, small, positive and interactional terms. They should focus on *who* has been doing *what*,

where, when and with whom, and might be asked either from the interviewees' or from somebody else's perspective, for instance:

- How has that changed?
- What have you been doing instead?
- When you stopped..... what did you do then?
- Who else noticed your being more...?
- What did they do when you.....?
- What did you do when she...?
- What was the first sign that...?

The interviewer may also ask "what else...?" (is better, did you notice, etc.), how the interviewee did that, or what happened so that the interviewee could see that happening:

- How did you do that?
- How did you know that was the right thing to do?
- How did you decide to do that?
- How did that help?
- In what way was that helpful to you?
- What needs to happen so that you can do more of it?

"The interviewer asks and follows up on the Progress Scale"

The Progress Scale has to be asked in the following way:

"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?"

Follow up questions serve the purpose of getting a description in specific, small, positive and interactional terms. They should focus on *who* is or will be doing *what, where, when and with whom*, and may be asked either from the interviewees' or from somebody else's perspective.

Follow up questions of the Progress Scales *may* be used to:

Amplify exceptions and/or improvements. For instance, the interviewer may ask:

- Now that you are at a..., how have things changed?
- What are you doing different now that you are at a ...?
- How did (someone else) notice that you were at a....?
- Who else may have noticed your being at a...?

- What do they do when you.....?
- What do you do when they...?
- What was the first sign for them that you got up to a...?

The interviewer may also ask "what else...?" (comes into that....., is different now that you are at a...), how the interviewee did go up to that point in the scale, or what happened so that the interviewee could go up to that point in the scale. For instance

- How did it happen that you went from ... to?
- How did you go from ... to....?
- How did you know that was the right thing to do in order to go up to a .?
- How did you decide to do that?
- How did that help?
- In what way was that helpful to you?
- How do you know you can do more of it?
- What needs to happen so that you can do more of it?

The interviewer may also ask how come things are not further down on the scale, how the interviewee has been able to keep at that point, what is the highest he/she has ever been on the scale, etc. For instance:

- How will you notice that you are at a... (one point more on the scale)?
- What will you be doing different when you are at a...?
- At a ... how often will you be doing....?
- What needs to happen so that you can go up to a....?

3. "The interviewer compliments the interviewee at the end of the session"

During the session the interviewer may compliment the interviewee by making remarks using the interviewee's language and quoting their statements (e.g. goals, exceptions, resources) on what they have done, are doing, or plan to do that is helpful, positive or valuable.

Compliments should be given at the end of the session, *within the last five minutes of the session.*

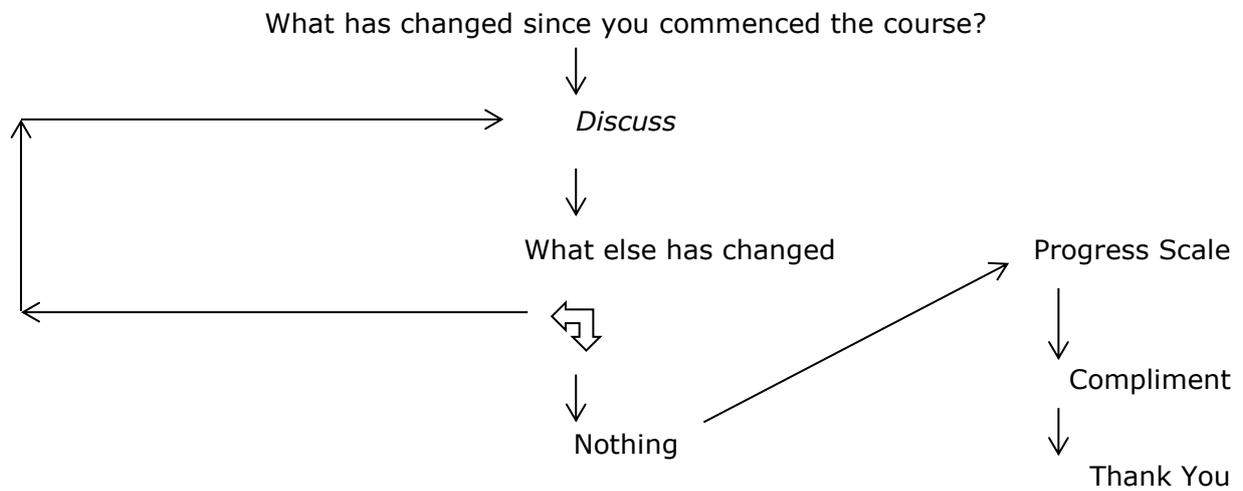
Examples of compliments:

- I am impressed with how well you described what has been happening to you since you commenced the course.

-I am impressed with how many things you are doing now that seem to work for you.

-I am impressed with how far you have come in such a short time.

The outline interview schedule is shown schematically below.



Appendix 3

Focus Group Session held on 15/10/09

Theme	Narrative
Active experience	I'd prefer it to be a bit more interactive. I find sometimes the time passes, it's gone from 9 to 11 and you haven't spoken. You maybe don't like to interrupt, but you might have something to say.
Challenges of previous practice + Moving towards change	I generally use quite a different approach, even though I'm beginning to understand how to apply it, I find it difficult to apply it, because of my concerns. So I find that kind of tricky, but when we talk about it, it becomes real to me; 'Oh yeah, I see how you could use that.'
Client empowerment	I feel I'm not having to pull rabbits out of hats, and, I never could, but somehow I thought I should.
Client empowerment	It stops me from looking at people as 'they're helpless', or that I'm the 'sage on the stage'. They're the experts and I don't need to be

	the 'sage on the stage'.
Client empowerment	<p>It's so much more helpful than, 'what's your problem, let me solve your problem'; 'I can't solve your problem', 'I don't want to hear it.'</p> <p>We're very poor at giving patients control, we pay lip service to empowerment and collaboration.</p>
Client empowerment + success	<p>With the client, I've found the energy change from what we've been talking about; they can take that away.</p> <p>Instead of people having a problem, they think, 'what can I do?', and they take it away.</p> <p>It's accessible for the client, it's successful for you, without much knowledge of why it works or what the 'ins-and-outs' are.</p>
Client empowerment	<p>The thing I like about the Miracle Question is that it's out of our hands.</p> <p>It's nothing to do with us; it's the power of the person. It's not us waving a wand, it's not us doing the miracle.</p> <p>It's 'something that just happens', and they experience it.</p>

Confidence	<p>The gap that we have now is a bit daunting.</p> <p>It feels like there should be some way of continuing to practice.</p>
<p>Confirming pre-course practice + Growing confidence</p>	<p>I've been thinking about solution focused for quite a while now, a year or so, even before I started the course</p> <p>I was playing with it with some clients, using little bits of it to see if it would go.</p> <p>Coming on the course gave me the encouragement and the confidence that I was lacking to actually ask the Miracle Question and discover that people wouldn't look at you, and just get up and walk out the room.</p>
<p>Confirming pre-course self + Client empowerment</p>	<p>I'm a bit wacky anyway;</p> <p>I often use a 'magic wand question' rather than the Miracle Question; but, it's really good 'cos you can apply it.</p> <p>It doesn't matter what the problem is, you can apply it. Because people know what that means, 'how nice would that be to feel like this'.</p> <p>I think, ultimately, that's what they're after.</p>
Deeper understanding	<p>Something I would have found useful, almost like a narrated transcript</p>

	<p>of a consultation, looking at the process parts of solution focused therapy, as well as the, sort of, deliberations, within the therapist's mind.</p> <p>A narrated transcript.</p>
Deeper understanding	<p>There's just so much depth to something which at the surface, you look at and you think it's just so formulaic.</p>
Deeper understanding	<p>Thinking about the rating scale and thinking I've got to make a situation better; got to get it to '10'.</p> <p>I think it helps to make things better without trying too hard.</p> <p>It's easier taking small steps rather than being overwhelmed by the whole situation.</p>
Embedding	<p>I find myself stopping myself asking why, or even wondering why.</p> <p>I find I just stop myself now.</p> <p>Even if I knew, how would it help?</p>
Embedding + Personal change	<p>Possibly putting too much focus on Steve's story about changing the settee; changing the furniture.</p> <p>I've got a new set of furniture about to arrive,</p>

	and I'm hoping will make my life a lot better.
Experimentation	Definitely affected my practice, that's been quite encouraging. So far, that's been quite tentative, but I've tried it out in relatively straight forward scenarios.
Experimentation	I've been able to transfer it into the context of 'don't dwell too much on the negatives and the issues that's there', but look at what potentially can help us find our own solutions. In a roundabout way it's been quite helpful.
Experimentation + Success	You expect the Miracle Question to be a big deal, but actually, the times I've used it, in the standard format, folk are just straight into it.
Experimentation + Recognition of learning	I haven't managed to find a phrase yet, to find a phrase that works. I tried a magic wand, and her response to that was, 'well I haven't got one, so it doesn't really matter'; that kind of finished the conversation. I wasn't experienced enough to, kind of, say, 'well, if you did though, what would you do then?' Which is what I should have done, but I didn't.

Experimentation	<p>What I do like is you see the client sort of sit back for a minute, and you can see their mind working, and I quite like that.</p>
experimenting	<p>There are some people that you actually use the format with, and it doesn't work, hardly at all.</p> <p>Maybe you get to learn either your limitations, or the limitations of the therapy for some people.</p> <p>I'm beginning to use it in my work, and also personally, just be aware of more strengths, more positive and being encouraging, myself.</p>
Experimenting + Challenge + Success	<p>I think it's given me an extra kind of tool in my box of things that I could use.</p> <p>I don't know if it's the most appropriate to use with everybody that I see, but it definitely agreed with people that I,</p>

	<p>kind of, struggled with in the past; to what I'd do with them next, and I think this is what I need to, kind of, help these people.</p>
<p>Experimenting + Challenge of previous practice + Moving towards change</p>	<p>Even after one day, it was successful enough to say, 'Actually, this might be useful in a difficult situation with this particular client'.</p> <p>Well, I could certainly see where I could, perhaps, use it in a brief way.</p> <p>And I've struggled with my practice, how I could do that in a way that was respectful of the client.</p>
<p>Personal change</p>	<p>I like what you said about the energy, I think I've actually experienced that myself. I can even feel the way the energy is being transferred to, not in a forced way, but almost in an automatic way, that is helpful for the work that I do and also for my home situation.</p>
<p>Positive expectation</p>	<p>It's quite good I don't know how it's going to come together. In time it will make sense; do more reading and use it more.</p>

	Think about it.
Recognition of learning	Good to have some videos. Some videos you watched in the first few weeks, You'd probably take a different perspective now.
Recognition of learning + Experimenting + Success	I've noticed that when you ask things like the Miracle Question, or, 'how would that help?', people come up with things; that, they themselves, surprise themselves with. In terms of 'what is it that I really want?' and then are able to discover that actually, this thing that I really want can no way happen in this situation. And they start to make connections.
Success + Experimenting	I've found it seems to be incredibly helpful; clients seem to be incredibly helped. Clients seem to find it really empowering. When they walk in the room and everything about them, their body language and their poise says, 'I am absolutely overwhelmed'. And by the end of the session there's just a difference,

	<p>the way they hold themselves, their voice. It's just a significant shift.</p>
<p>Use in practice + Active experience + Client empowerment</p>	<p>I notice in my practice, even when I haven't been thinking that I'm going to go through the whole format, something's just come to light and I've suddenly gone into that role, and it's a kind of useful mode, because I get taken away from the responsibility I felt for getting the client better, or for giving them something.</p> <p>It's made me more relaxed, more reflective and enabled to put it back to them.</p>

Appendix 4

Transcript of Interview #43

- Steve 00.00** Okay; so that'll just sit there quietly. Uh ... thank you for agreeing to do the interview Dawn. The question that I'm starting with in all the interviews is ... you've, you've been involved in the course since the first cohort; 2006, and eh, I think you were not unaware of things before that ... eh, so ... first question then. What's changed since you did the solution therapy training?
- Participant 00.38** I've become a hell of a lot more confident in my job because I've got a ... structure to follow. Although I don't use the whole structure all the time, I use bits and bobs of it that are suitable for the individual client ... and the clients are responding well to it. And some of them now; scaling questions for example, I get, 'I'm at a 4 today, Dawn', before I even ask a question; so my clients get it, and they work within it really well as well, and It makes me more confident, and the success rate of discharges has increased as well.
- S 01.13** Right, okay. So it's made you more confident as a practitioner ... uh, you're obviously using it to an extent that your client's ... uh, they're working with it as well now, independent of you almost ... and it's had an impact on your, sort of, clinical outcomes and suchlike; discharge rates going up ... uh; okay. Anything else? Any other impact?
- P 01.35** It's impacted on my personal life as well. I utilise it all the time with my kids and my parents and ... it just makes me more confident all round in any situation I suppose.

- S** **01.47** Right.
- P** **01.47** I find it brilliant.
- S** **01.49** So ... when you say it's made you more confident in any situation ... uh, is that just ... generally more confident, or are you ... using solution focused techniques ... in your private life and that's what's made you more confident?
- P** **02.09** I'm using it all the time. I use it in my private life as well and it's ... the kids work better with me now. (laughs)
- S** **02.14** Right! (laughs)
- P** **02.16** So, I use it everywhere.
- S** **02.19** Uh-huh. And is that in a ... deliberate sense or is that just because it's the obvious thing to do?
- P** **02.24** No. It just happens. I don't realise I'm using it now.
- S** **02.30** Right, okay ... we'll ... eh ... come back to that later. But ... eh ... let me go back then, right ... say ... before you did the solution therapy training, right?
- P** **02.44** Uh-huh.
- S** **02.45** How would you describe your practice at that time?
- P** **02.48** A bit sketchy. It was ... not research based, evidence ... obviously, my career was huge, it's over 27 years I've got in the NHS, so a lot of it wasn't research based. I lacked a lot of confidence; I wasn't long in the CPN department. Personally I lack confidence, but professionally I lack

confidence as well; just kind of being beaten to the ground by certain members of staff in the past, and was just building it up again ... but with the solution it's just taken off; I'm back to being me again I suppose.

S **03.20** Right. Ah ... so ... both personally and professionally you lacked confidence at that time, you would say.

P **03.29** Uh-huh.

S **03.30** And, eh, your practice ... although by that point I guess you had over twenty years, more than twenty years experience, it wasn't research based, it wasn't evidence based ... eh ... if I had been sort of, a fly on the wall, or whatever, and seeing you practice; what would I sort of, what would I have seen you doing? What approaches would I have ...

P **03.56** It was very instinctive, it was very ... a lot of it was what the clients came to me with, and I would work with what they had come to me with ... but ... it was also a wee bitty off the wall slightly too, I suppose. It was a wee bitty odd, because whatever they came with I would try to work out ... with them, the problem; Problem Solving more than anything. Whereas now, we work on it together, find the solution, and they find their solutions rather than me. But, it was very much Problem Solving ... me telling them what to do.

S **04.34** Right. So they, you said you would work with what they bring?

P **04.37** Yeah.

- S** **04.37** In what sense?
- P** **04.39** If they came with a crisis, like something to do with their kids, we'd look at how they could help that. But, it would be me telling them.
- S** **04.49** Okay; so they came with a problem, that was the focus of the interaction and it was largely you drawing on your experience to ... tell them.
- P** **04.59** Right.
- S** **04.59** Right. Okay. And was there any sort of ... models involved in that, or was it just intuition?
- P** **05.05** Intuition. I don't like models. (laughs)
- S** **05.09** Right. (laughing) Okay. And how ... how effective was that for you? How comfortable was it?
- P** **05.17** Because it was instinctive, it was okay. I was comfortable with what I was doing ... but I knew it wasn't ... 'right'. Although I lacked confidence in what I was doing as well, it's a bit contradictory; it felt natural for me.
- S** **05.30** Uh-huh. Okay, so ... it felt natural ... but you lacked confidence in it?
- P** **05.37** Uh-huh.
- S** **05.40** Can you tease that out just a wee bit more, that's interesting?
- P** **05.44** I don't suppose I trusted what I was saying ... I think

that's more what I'm saying. Although it felt natural what I was saying, I didn't trust that it would be useful to the clients.

- S** **05.53** Right. Uh-huh, and ... so, it sort of felt ... the obvious thing to say, the natural thing to say ...
- P** **06.02** Uh-huh.
- S** **06.02** ... to be helping ... but there was a feeling that you should be doing something ... different?
- P** **06.07** Yeah.
- S** **06.07** Something ... Yeah? Okay. Uh ... and ... did you have an idea of what that something different was?
- P** **06.19** No.
- S** **06.20** No?
- P** **06.20** Not at the time. I was looking for something ... but I hadn't come across anything I felt I could work with.
- S** **06.30** Right. Uh ... so ... you were looking for something that fitted with you?
- P** **06.36** Uh-huh.
- S** **06.36** Yeah? And what ... was there anything specific that you'd looked at before, or were you just sort of open to ideas?
- P** **06.43** I'd kind of looked into Thorn, looked at CBT ... and I knew that they weren't for me at all.

- S** **06.49** Uh-huh. Why was that?
- P** **06.51** Too drawn out ... expects a lot of the clients and a lot of my clients have been in the service too long, or have been through all that kind of thing in the past, and they didn't like it; they said they didn't like it ... and it ... didn't fit with me, it didn't work with me.
- S** **07.08** Uh-huh, uh-huh.
- P** **07.09** And then I did one, a one day solution awareness, and that was the one that I really liked, and wanted to learn more about; so that's why I applied for this.
- S** **07.18** Right, okay.
- P** **07.18** It just seemed to click ... this was something I could work in.
- S** **07.22** Okay. So, the, the sort of, the awareness raising of Thorn or CBT, you heard about that, but it didn't fit for you, it didn't click ...
- P** **07.31** No.
- S** **07.31** ... one day awareness of solution therapy and that clicked and sort of ...
- P** **07.36** Yeah.
- S** **07.39** ... What was it that clicked, do you think?
- P** **07.41** I think it was the approach because ... you've got to be

honest, which I tend to be with my clients anyway. But it was also the simplicity of it ... or how it appeared to be so simplistic ...

S **07.54** Uh-huh, uh-huh.

P **07.55** ... and you can do it without the client even realising that you're ... working in an approach ... It just worked with my instincts; I suppose ... it worked for me naturally. Built on my natural ... skills.

S **08.14** Uh-huh. Okay. Uh ... so, when did you do the one day workshop?

P **08.19** It was about a year and a half before I started the first cohort.

S **08.26** Right. Uh ... so ... that; that raised your awareness ...

P **08.32** Uh-huh.

S **08.33** ... and that then would probably be the sort of beginning of your awareness of solution therapy and the beginning of your training in it perhaps?

P **08.41** Uh-huh.

S **08.41** So you applied to come on the course ...

P **08.44** Yep.

S **08.44** ... eh ... what were your expectations coming on the course?

- P** **08.51** None, because I had read a wee bit about solution; not an awful lot, but I'd read a wee bit about it and I wanted to come to it with an open mind. I tend to do that with most things ...
- S** **09.00** Right.
- P** **09.01** ... so I don't expect ... anything, if you like; but I think if you come with an open mind you're more open to learning.
- S** **09.10** Right. Uh-huh ... uh, so ... what did you think you would get from the course?
- P** **09.17** Some form that I could work ... that the 'higher-ups' could see was a research based, or a structure, that I could work to, that they could understand. I didn't expect it to have the impact that it has had ... at all.
- S** **09.33** Right. So ... you were looking for a model that you could work in; that would be recognised as a, a model?
- P** **09.41** Yeah.
- S** **09.41** As opposed to ... just having a chat with somebody?
- P** **09.45** Yeah.
- S** **09.46** ... And does that reflect the ... the confidence thing you were ...
- P** **09.51** Uh-huh. Definitely.
- S** **09.51** ... you were saying? ... Would that have made you more

confident?

P **09.56** Yeah.

S **09.58** Why? ... Why would that have ...

P **09.59** Because I was feeling I was a bit of a dinosaur in the service. .

S **10.04** Uh-huh.

P **10.04** All the youngsters coming through, knowing all models and everything like that; I mean I hadn't a clue what they were talking about half the time

S **10.09** Right, uh-huh. Okay ... so to have a model that you could work with ... yeah? Okay, right ... so ... you're coming on the course expecting to get something that would give you a training in a model that you could use in practice ... to what extent did the course meet your needs, your expectations; whatever?

P **10.38** I suppose it passed them. Completely. Well, when I first came to the class I wouldn't speak or anything, and the thought of doing the video recording; I was just about under the table with it ...

S **10.47** Uh-huh.

P **10.48** I think I was one of the quietest in the cohort...

S **10.51** Right ...

P **10.51** ... but ... em, since then I've become really vocal about

solution.

S **10.55** Uh-huh.

P **10.55** As you're aware of. Everybody gets told about it.

S **10.59** Right. How, how did that happen? 'Cause I remember that person back there; how did that happen?

P **11.05** I don't know, Steve. I don't know; I really, I've looked at trying to figure it out. I think it's because it works for me naturally, and it's helped to draw out the confidence issues, eh ... it's something that I really enjoy, really like, and I think other people should learn how to do it.

S **11.22** Uh-huh.

P **11.23** I remember when we'd finished the class and we'd ... the first few days of class; Paul and I were having a talk ...

S Uh-huh.

P ... and both of us have got long service, and he says; Paul say, "I wish I'd known about this thirty years ago", and I said, "I wish I'd known about it twenty-five years ago", because at least then we'd have been doing something constructive with we're clients all these years.

S **11.41** Uh-huh.

P **11.41** And it just kind of struck, that, this can help people.

S **11.46** Right. Uh-huh.

- P** **11.47** And it does help people; we seen it when we were practising in the first ... sessions, and things; going out from class and trying it on we're patients and everything, and it ... you could see lights going on in their eyes. "I'm responsible", "I'm the one that can change", and I think that's why I like it so much, that they take on the responsibility of their conditions, and they learn from it, and move forward.
- S** **12.10** Right; uh ... So you're having this conversation about "I wish I'd known about this twenty, thirty years ago"... ahh ... we'd be doing something constructive ... does that suggest that you felt you hadn't been doing something constructive ... all those years?
- P** **12.28** Partially. 'Cause we didn't know about it, we didn't realise it was, what it did.
- S** **12.34** Uh-huh.
- P** **12.35** But, I think, 'cause it works for me instinctively, it goes with my natural ... way of working, I suppose; it's exacerbated, no; exaggerated on that ...
- S** **12.44** Uh-huh.
- P** **12.45** ... it's made me much more aware, and it's ... I can explain to clients in a clearer way ...
- S** **12.51** Right, yeah ... Right ... so, you can explain to clients, because you instinctively understand it?
- P** **13.00** Uh-huh.

- S** **13.01** Uh-huh? Right ... so, you've probably answered this, but if I was to scale it; right, the 'solution question' ...
- P** **13.09** (laughs)
- S** **13.09** ... eh ... if 10 was that you got everything you expected of the course, and 0 was, it was a waste of time ...
- P** **13.17** 10
- S** **13.17** ... where would ... 10? Ahh ... I thought you might say that. (laughs)
- P** **13.21** (laughs)
- S** **13.22** Ahh ... What would have enhanced it; what would have made it 11?
- P** **13.30** ... No video! (laughs)
- S** **13.31** (laughs)
- P** **13.32** No ... maybe a wee bit longer on some of the theory stuff ...
- S** **13.37** Uh-huh.
- P** **13.37** ... to get we're heads into the theory slightly ... better, 'cause, like I say, it had been years since I'd really studied anything properly ...
- S** **13.43** Uh-huh.
- P** **13.44** ... and getting your head back into the studying, and the theory side of it, when you have had such a huge gap ...

- S** **13.51** Right.
- P** **13.51** ... it takes a lot out of you, and it does take time.
- S** **13.55** Huh-huh.
- P** **13.55** So, maybe an extra day in college, or some; sorry uni, or something like that; just to get we're heads into the theory side of it a wee bit better.
- S** **14.03** So, that would have helped ...
- P** **14.05** Make it an 11, yeah.
- S** **14.06** Yeah? Right ... and ... does that have a lasting impact; like, eh ... do you feel ... now, that you've ... made up for not having that day, or is that something you would still find useful, do you think?
- P** **14.22** I would still find it useful. Useful; I would still find it useful ...
- S** **14.25** Right.
- P** **14.25** ... Just as like a refresher, more than anything ...
- S** **14.29** Uh-huh. Right ... okay. Ah ... so; you came on the course 2006, finished it, and you came back in 2008 for the second course ... how would you describe you're practice now?
- P** **14.50** Completely solution focused.

- S** **14.52** Uh-huh.
- P** **14.52** It's more of an approach, and it's developed slightly to my style ...
- S** **14.59** Uh-huh.
- P** **14.59** ... but it's completely backed up by the solution. As I say, clients use the scaling questions, or ... they go back to scaling all the time, or some of them will go back to the Miracle Question ... they might talk about their Positive Future Scenario, rather than the Miracle Question, but they bring it up.
- S** **15.19** Uh-huh ... right.
- P** **15.19** If I mention it, they know exactly what I'm talking about; we can have a complete ... positive session with them ...
- S** **15.25** Uh-huh.
- P** **15.25** That they go away feeling empowered. I've got clients with Borderline Personality, which ... I know is a bone of contention with some people, that they're coming to me now saying, "I get this Dawn, it's my responsibility, nothing's going to change unless I change it."
- S** **15.42** Uh-huh.
- P** **15.42** And that; these people have been in the service for years and years and years, and usually nothings worked for them.
- S** **15.47** Right. Uh ...

- P** **15.48** And it's just very slowly introduced to them, and gradually ... and now it's got, the whole sessions are solution focused.
- S** **15.55** Uh-huh.
- P** **15.57** And they understand where I'm coming from; they can scale for their feelings 'cause they don't understand their feelings,
- S** **16.02** Uh-huh.
- P** **16.03** Even my ehm ... some of my clients with like schizophrenia, or depression, or something like that, they even use it.
- S** **16.10** Uh-huh.
- P** **16.11** "My Positive Future Scenario, Dawn", as one of my guys says, "is getting back to my swimming". And he sees that as a step forward.
- S** **16.18** Right.
- P** **16.19** So they all use it; they're all starting to talk the language ... eh ... it's quite good to see ...
- S** **16.23** Uh-huh.
- P** **16.24** ... and they're taking responsibility for their illnesses themselves.
- S** **16.26** Right! Uh-huh ... so ... you obviously work with people on

a long term basis ...

- P** **16.33** Most of them are long term, yeah.
- S** **16.34** ... eh, and you said ... that you're entirely solution focused; you've adapted it to yourself. So ... what does that look like?
- P** **16.44** It's not the, ehm, complete structure ...
- S** **16.48** Hu-huh.
- P** **16.48** ... it's questions here, there, it's the language, it's ... the way I talk, the way I phrase questions ... ehm ... the ... simplicity of it, I mean one women said, "If you go `really!' once more, I'm gonna slap you". (laughs)
- S** **17.03** (laughs)
- P** **17.03** But it's just being able to let them see that they're in charge, they're in control of their conditions; they're the expert, not me.
- S** **17.14** Right. Uh-huh.
- P** **17.14** And that helps. And it seems to work for them.
- S** **17.18** Right. So, it's less about, ahh ... technique; it's less about specific questions, and more about an approach?
- P** **17.29** Yeah.
- S** **17.30** A way of ... a way of working, a way of thinking?

- P** 17.34 Well, both. Both I suppose.
- S** 17.35 Yeah? Right. And ... they're starting to; well, not starting to, they are now ... ah ... sort of, internalising, or owning, that way of thinking; they're thinking the same way?
- P** 17.50 Yeah.
- S** 17.52 Yeah? Ahh ... okay. Eh ...
- P** 17.55 The short term clients, some of them have been through the service as well, in the past.
- S** 18.00 Uh-huh.
- P** 18.00 And they find this way, because I don't ask about their past.
- S** 18.04 Uh-huh.
- P** 18.04 Obviously, I've got to, the initial assessment interview, but after that I don't ask; whatever it is they come with, and they ... even the short term clients get it.
- S** 18.13 Uh-huh.
- P** 18.13 And ... there's a couple of them that get re-referred, but it's only short spells I see them, and they specifically ask to come back to me, 'cause they understand the way I talk. (laughs)
- S** 18.23 (laughs)
- P** 18.25 So, I see them for short spells; a maximum six

appointments is usually what it works out at, sometimes it's two, sometimes it's three, and they're off again and they're well for about another eighteen months. Something else, or another crisis crops up, and they come back.

- S** **18.41** So is this people that would traditionally just be on the caseload forever?
- P** **18.44** Constantly.
- S** **18.47** Right. Uh-huh. So they're now coming back for two, three, five, six sessions ...
- P** **18.52** Yeah.
- S** **18.52** ... and then going on again? Right. Wow. Uh ... how does that feel?
- P** **18.58** Brilliant! It's brilliant for them; they're not seeing a professional all the time. For me, it's ... meaning that I can move on and see someone else, but they know that it they're; they get unwell again they can come back.
- S** **19.10** Uh-huh.
- P** **19.11** And we ... never go back to where they were before, we always start from that point they come back to me with.
- S** **19.18** Right.
- P** **19.18** Ehm, so they don't ; they don't feel they've got to repeat the whole story.

- S** **19.22** Hmm. Uh-huh.
- P** **19.23** Which makes it easier for them ...
- S** **19.25** Right. Uh-huh.
- P** **19.28** But it feels good eh, for them, that they're only getting short spells with me now.
- S** **19.34** Right. Okay. That's ... that's really ... really interesting. Ah ... so, you said that eh ... it's changed your confidence, in your practice.
- P** **19.43** Uh-huh.
- S** **19.44** Ah ... is that because you now have a model ... ?
- P** **19.49** Despite hating models, yeah. (laughs)
- S** **19.50** I wondered about that, uh-huh. (laughs)
- P** **19.55** Yeah, I suppose it is. It's within a model, it's within a framework that I can ... that I understand, and if I understand it, anyone can understand it.
- S** **20.03** Uh-huh. Right. I'll let that pass for the moment, cause that's not what we're talking about. (laughs)
- P** **20.10** (laughs)
- S** **20.11** Uh ... so ... so, clinically it's changed you're whole approach ...
- P** **20.18** Uh-huh.

- S** **20.20** ... from a sort of ... nebulous, trying to provide the answers, to ...
- P** **20.25** It was almost like a rescue service I was providing before.
- S** **20.28** Right. Uh-huh. Uh ... and now ... how would you describe it?
- P** **20.33** Empowering.
- S** **20.34** Right. Okay, huh-huh. Ah ... and ... in your ... your own life; your, your ... private life ... eh ... that, that way of thinking has ... is also evident?
- P** **20.52** Yeah. Well despite Stephen going to the 'dark side', yeah. 'Cause he didn't know what he wanted to do ...
- S** **20.59** Right.
- P** **20.59** ... and we just, kinda ... done some solution focus and ... he knew he wanted to do something in the caring profession ...
- S** **21.04** Right.
- P** **21.04** ... he hadn't a clue where he wanted to go, what he wanted to do with it, 'cause he flunked his Highers, which meant he couldn't go with Medicine, what he wanted to do.
- S** **21.10** Right.
- P** **21.10** So, I kinda, did some solution focus with him, and ... he ended up going into Nursing.

- S** **21.16** Right. Uh ... did you tell him?
- P** **21.19** (shakes head)
- S** **21.19** How did you; how did you avoid telling him?
- P** **21.22** I told him not to do it! (laughs)
- S** **21.24** (laughs)
- P** **21.25** It was some ... no, I just says, "well look, you've got to sit down and think, you've got to look through your ... your options"...
- S** **21.31** Uh-huh.
- P** **21.31** ... ehm, "but, what would you tell me?", and I said, "it's not my choice, it's your choice, you think it through, I'll be there and we'll discuss ...
- S** **21.39** Uh-huh.
- P** **21.39** ... your options ... and what I know from the service; if there's any ... possible reductions in jobs in that area, or something, but you're the one who wants to do this, you're the one who needs to become ... aware of what's happening out there."
- S** **21.54** Uh-huh.
- P** **21.55** And we did the Miracle Question and that... in a ...
- S** **21.58** Right.

- P** **21.59** ... different way. Cause, obviously I couldn't sit down and ask him the Miracle Question ...
- S** **22.02** Right.
- P** **22.03** ... and don't ask me what it was; 'cause I can't remember how I worded it now.
- S** **22.05** Uh-huh.
- P** **22.06** And ehm ... he seen himself working in one of the nursing professions.
- S** **22.12** Right. Uh ... so, very much putting the focus on him, and his future; his positive future scenario, and all that sort of stuff? ... I know you can't compare something that didn't happen, but eh ... is that likely to have been different to how you would have dealt with that ...
- P** **22.34** Definitely. Definitely. It would have been very much 'mother head' on; 'you will do this, you will do this'. Or 'you should do this', not 'you will do this'; 'you should do this'. 'Don't even think about doing that; that's just nonsense, you'll never pass. Try this'. And it just wouldn't have worked.
- S** **22.49** Right.
- P** **22.50** 'Cause he's quite a ... he's quite like me; he's quite stubborn in a lot of ways.
- S** **22.53** Uh-huh? Right. So, circumvent his stubbornness by making him the boss?

- P** **23.00** Uh-huh.
- S** **23.02** Right. And is that an example of just how you approach issues now?
- P** **23.05** Yeah.
- S** **23.06** Yeah ... ehh ... well; okay. That's ... that's given me a lot of really useful stuff. Uh ... I'm sort of sitting here cheering when you say somethings, 'Oh yes!' (laughs) ... Before we finish ... ah ... what I ... do with this now, what I will do is, I will listen to it several times, and I will be taking the main themes out of it. But ... ah ... to make that a little bit easier for me, eh ... sort of 'final question' ... eh ... in a couple of sentences, on the 'back of a postcard', or whatever; in a nutshell ... what has been the impact of solution therapy training been, for you?
- P** **23.57** Steve, how can I do this in a few words; you know what I'm like ...
- S** **24.00** Well, however many words it takes; go on!
- P** **24.02** It gives me a structure, it allows my patients to be in power instead of me. And ... it helps them move forward with their lives, so it's given me the confidence to allow people to move forward.
- S** **24.15** Hu-huh. Okay; thank you very much.

Appendix 5

Interview #43: Utilising Colaizzi's seven-step method of data analysis

Transcript	Meaning	Theme
I've become a hell of a lot more confident in my job because I've got a structure to follow.	SFT training gave me a structure to work with, and that has made me more confident in my role.	Confidence in role 43.1
Although I don't use the whole structure all the time, I use bits and bobs of it that are suitable for the individual client and the clients are responding well to it.	I choose which parts of the model to use, based on my perception of my client's needs.	Eclectic use of model 43.2
I get, 'I'm at a 4 today, Dawn', before I even ask a question; so my clients get it, and they work with it really well.	My clients now use scaling without a prompt from me.	Client engagement Trust 43.3
It makes me more confident, and the success rate of discharges has increased as well.	Seeing the model work has increased my confidence.	Confidence in model 43.4

<p>It's impacted on my personal life as well.</p> <p>I utilise it all the time with my kids and my parents.</p> <p>It just makes me more confident in any situation I suppose.</p> <p>I find it brilliant.</p>	<p>I use SFT in my own life, outside of therapeutic practice.</p>	<p>Eclectic use of model</p> <p>43.5</p>
<p>I'm using it all the time.</p> <p>I use it in my private life as well and the kids work better with me now.</p> <p>So, I use it everywhere.</p>	<p>I use SFT in my own life, outside of therapeutic practice.</p>	<p>Eclectic use of model</p> <p>43.6</p>
<p>It just happens.</p> <p>I don't realise I'm using it now.</p>	<p>It seems natural to interact in this way.</p>	<p>Internalising</p> <p>43.7</p>
<p>My previous practice was a bit sketchy.</p> <p>It wasn't evidence based, I lacked a lot of confidence; I wasn't long in the CPN department.</p>	<p>I didn't believe in the legitimacy of my previous practice, and lacked confidence in my ability. I didn't have a lot of experience as a CPN.</p>	<p>Lack of confidence</p> <p>43.8</p>
<p>Personally I lacked confidence, but professionally I lacked confidence as well; just kind of being beaten to the ground by certain members of staff.</p> <p>But with the solution it's just taken off;</p>	<p>SFT has restored my self confidence.</p>	<p>Empowering</p> <p>43.9</p>

<p>I'm back to being me again I suppose.</p>		
<p>It was very instinctive, a lot of it was what the client came to me with, and I would work out what they had come to me with.</p> <p>It was also a wee bit off the wall too.</p>	<p>My previous practice was based on what I thought would help. It was very subjective.</p>	<p>Intuitive</p> <p>43.10</p>
<p>I would try to work out, with them, the problem; Problem Solving more than anything.</p> <p>Whereas now, we work on it together, finding the solution, and they find the solution rather than me.</p> <p>It was very much Problem Solving; me telling them what to do.</p>	<p>My previous approach was a Problem Solving approach.</p>	<p>Problem solving</p> <p>43.11</p>
<p>If they came with a crisis to do with their kids, we'd look at how they could help that.</p> <p>But, it would be me telling them. It was intuition. I don't like models.</p>	<p>I would respond to the problem the client presented with. It was very personal, I didn't like working with formal models.</p>	<p>Intuitive</p> <p>43.12</p>
<p>I was comfortable with what I was</p>	<p>Although I believed in the</p>	<p>Lack of</p>

<p>doing, but I knew it 'wasn't right'. Although I lacked confidence in what I was doing as well, it's a bit contradictory; it felt natural for me.</p>	<p>advice I was giving, I didn't think it was my job to give advice.</p>	<p>confidence (paradoxical) 43.13</p>
<p>I don't suppose I trusted what I was saying. Although it felt natural what I was saying, I didn't trust that it would be useful to the clients.</p>	<p>I didn't believe I was being really helpful, but didn't know what else to do.</p>	<p>Lack of confidence 43.14</p>
<p>I was looking for something, but I hadn't come across anything I felt I could work with.</p>	<p>I was looking for some other way of working.</p>	<p>Searching 43.15</p>
<p>I'd kind of looked into Thorn, looked at CBT, and I knew that they weren't for me at all. Too drawn out, expects a lot of the clients; I mean a lot of my clients have been in the service too long, or have been through all that kind of thing in the past, and they didn't like it; and it didn't fit with me, it didn't work with me.</p>	<p>The models I had explored didn't fit my way of being.</p>	<p>Traditional models didn't fit</p>

		43.16
I did a one-day solution awareness, and that was the one that I really liked, and wanted to learn more about; so that's why I applied for this. It just seemed to click; this was something I could work in.	I had a brief exposure to SFT, and it seemed to fit my way of being.	Intuitive difference A-ha moment 43.17
You can do it without the client even realising you're working in an approach. It just worked with my instincts. I suppose it worked for me naturally. Built on my natural skills.	SFT allows me to work in a way that fits with my way of being.	Intuitive fit. 43.18
I had read a wee bit about solution; not an awful lot, but I'd read a wee bit about it and I wanted to come to it with an open mind. I tend to do that with most things, so I don't expect anything, I think if you come with an open mind you're more open to learning.	I was looking for something, but had no great expectations of what I would get from SFT training.	Searching 43.19
Some form that I could work with, that the 'higher-ups' could see was research based, or a structure that I could work to, that they could understand.	I was looking for something that would provide a legitimate structure to what I was doing.	Professional validation

<p>I didn't expect it to have the impact that it has had at all.</p>		<p>43.20</p>
<p>I was feeling I was a bit of a dinosaur in the service. All the youngsters coming through, knowing all about models and everything like that; I mean I hadn't a clue what they were talking about half the time.</p>	<p>I felt I lacked contemporary credibility.</p>	<p>Personal validation 43.21</p>
<p>When I first came to the class I wouldn't speak or anything, I think I was one of the quietest in the cohort, but since then I've become really vocal about solution. Everybody gets told about it.</p>	<p>I used to be very quiet, but now I'm more confident. I tell everyone about the solution focused approach.</p>	<p>Enthusiasm 43.22</p>
<p>I think it's because it works for me naturally, and it's helped to draw out the confidence issues, it's something that I really enjoy, really like, and I think other people should learn how to do it.</p>	<p>This is an approach that sits comfortably with me. I believe in it.</p>	<p>Intuitive fit. 43.23</p>
<p>I remember when we'd finished the class and Meggy and I were having a</p>	<p>My colleague and I have been nurses for many years. It would have been</p>	<p>Confidence in model.</p>

<p>talk; and both of us have got long service, and he says "I wish I'd known about this thirty years ago", and I said, "I wish I'd known about it twenty-five years ago", because at least then we'd have been doing something constructive with our clients all these years.</p>	<p>useful to know about this approach when we began.</p>	<p>43.24</p>
<p>You could see lights going on in their eyes. "I'm responsible", "I'm the one that can change", and I think that's why I like it so much, that they take on the responsibility of their conditions, and they learn from it, and move forward.</p>	<p>There comes a point where clients recognise they can take control of their lives and move forward.</p>	<p>Client control. 43.25</p>
<p>Maybe a wee bit longer on some of the theory stuff; 'cause it had been years since I'd really studied anything properly and getting your head back into the studying, and the theory side of it, when you have had such a huge gap it takes a lot out of you, and it does take time.</p>	<p>I would have benefitted from more time spent studying solution focused theory.</p>	<p>More theory. Evidence base. 43.26</p>

<p>It's more of an approach, and it's developed slightly to my style.</p> <p>Clients use the scaling questions; they go back to scaling all the time, or some of them will go back to the Miracle Question.</p> <p>They might talk about their Positive Future Scenario, rather than the Miracle Question; but they bring it up.</p>	<p>My clients take ownership of the approach.</p>	<p>Client control.</p> <p>43.27</p>
<p>They go away feeling empowered. I've got clients with Borderline Personality, they're coming to me now saying, "I get this Dawn, it's my responsibility, nothing's going to change unless I change it."</p>	<p>This approach enables my clients to take control of their lives.</p>	<p>Client control.</p> <p>43.28</p>
<p>And it's just very slowly introduced to them, and gradually it's got, the whole sessions are solution focused.</p> <p>And they understand where I'm coming from; they can scale for their feelings 'cause they don't understand their feelings.</p>	<p>Over time, clients engage in this way of working. It enables them to talk about their emotions.</p>	<p>Client control.</p> <p>Acceptability.</p> <p>43.29</p>
<p>It's the language, it's the way I talk,</p>	<p>The way in which I use language conveys to clients</p>	<p>Use of language.</p>

<p>the way I phrase questions, the simplicity of it.</p> <p>I mean one women said, "If you go `really!' once more, I'm gonna slap you".</p> <p>But it's just being able to let them see that they're in charge, they're in control of their conditions; they're the expert, not me.</p>	<p>that they are the expert in their lives.</p>	<p>Client control.</p> <p>43.30</p>
<p>I see them for short spells; a maximum six appointments is usually what it works out at. Sometimes it's two, sometimes it's three, and they're off again; and they're well for about another eighteen months. Then something else, or another crisis crops up, and they come back. It's brilliant for them; they're not seeing a professional all the time. They know that if they get unwell again they can come back.</p>	<p>I see clients for brief episodes of care, and they are enabled to continue independent lives with minimal input from services.</p>	<p>Brevity.</p> <p>Client control</p> <p>43.31</p>
<p>It's within a model, it's within a framework</p>	<p>This is a model that empowers clients.</p>	<p>Confidence in model.</p>

<p>that I can understand.</p> <p>It was almost like a rescue service I was providing before.</p> <p>Now it's empowering.</p>		<p>43.32</p>
<p>It would have been very much 'mother' head on;</p> <p>'You will do this, you will do that'.</p> <p>'Don't even think about doing that'.</p> <p>And it just wouldn't have worked.</p>	<p>I would have been very directive with my family before I studied the solution focused approach.</p>	<p>Use of model in own life.</p> <p>Eclectic use.</p> <p>43.33</p>
<p>It gives me a structure.</p> <p>It allows my patients to be in power,</p> <p>instead of me.</p> <p>It helps them move forward with their lives;</p> <p>so it's given me the confidence to allow people to move forward.</p>	<p>This model provides a structure to enable me to enable my clients.</p>	<p>Confidence in model.</p> <p>Confidence in self.</p> <p>43.34</p>

Appendix 6

Formulated Transcript of Interview with Dawn.

Transcript	Formulated Meaning	Code
Working in a team, you've got to kind of work alongside the other people more. And if somebody's already started something with a client you've got to kind of follow that through so you, in relation to solution focus, you're maybe not getting to do what you would do because the recovery wellness plan doesn't allow you to.	Ward working is about team work. You have to go with the plan.	1
So working in a team is, you've got less chance to utilise solution focused fully and that kind of annoys me at times because I've got to go with what the other people are doing.	You have to go with the team plan.	3
So, that if a new admission comes in you kind of, if they're in your team, you look and see who's got the least patients and that person's made the named nurse. So you've got to, if it's behavioural or problem solving or whatever, you've got to kind of go with what they want done. But, as I said, you always manage to get some tiny wee bit of solution in there whether it's getting them to scale or look at things slightly differently out the box. You can still do it with the problem solving and the behavioural approach.	Nurses have to be team players. You can be innovative though; I am a bit of a maverick.	4 5
When I'm, if they're doing the problem solving, I'll get them to scale how big the problem is. And then, get them to look at it again and think	You can adapt SFT to other approaches.	7

<p>'Well, if you tried to do this', because it's the problem solving approach, 'what would happen if you said this? Where would that change the scale to?' and it's just trying to get them to change it slightly from a problem but not changing it solution focused but just changing the problem slightly and scaling it again and then and then I kind of leave the interview at that point. And leave them with it.</p>	<p>I believe in giving responsibility to patients.</p>	<p>8</p>
<p>And they usually come back when I speak to them next time, "D, see that thing you were saying?" "Aye." "If I did this, would that help do you think?" And I'd say, "Well, I don't know. You have to try it and see." And I still leave it with them because I'm not going to do it for them but it's still looking at – they're still looking – they're still thinking of it as a problem but they've actually come up with the solution themselves and I leave them with it.</p>	<p>Patients respond positively to my approach.</p>	<p>9</p>
<p>Some of them are doing really really well because it's dual diagnosis a lot of the clients we have in our ward and in my team. The ones with the drug issues are less likely to respond to it depending on where they are on the road of recovery. If they're ready to make change it works better, if they're not it's a waste of time but you've still got to be seen to be doing something.</p>	<p>SFT is effective with 'difficult' clients. But it depends on the client's level of motivation.</p>	<p>10</p>
<p>The care plans, they're all individualised, we all have our own style and mine are solution focused approached. There's like, in the action</p>	<p>SFT fits with current care plans It's an effective and quick</p>	<p>12 13</p>

<p>plans there's scaling, there's tasks. That's the two that I tend to use in the ward, there are some exceptions as well but the two that I do tend to use are the tasks and the scaling. And at the minute we've got, it's just a nightmare in the hospital just now really short staffed and patient's from other areas are in everybody else's wards because wards are full but there's one doctor that I'm working with from another ward who's patient's working really working well with a solution approach and he's actually put in the notes that he wants us to continue doing it. He wants this approach utilised with her and he's also spoke to the psychologist and wanting her to, kind of, use it was well now. So, because she's responded really well and really quickly to it. And she's one of these worrying about worriers and if you give her a task she has to do it in half an hour so it's getting her to ease back, chilling out a wee bit, think things through less in depth and it seems to be working really well with her, she's starting to come up with solutions of her own now. That's, what, three weeks she's been admitted. And she's "When you go on holiday, what am I going to do?" "I dunno what you're going to do." "Oh, well I'll just have to think things through myself differently won't I?" "Do you think that'll help?" Kind of approach and she's getting there with it. And it's really helping."</p>	<p>intervention.</p> <p>I'm getting a positive response from the Doctors on my ward.</p> <p>I'm giving responsibility back to the patient.</p>	<p>14</p> <p>15</p>
<p>One in the team, one of the other – well, sorry, two of the nurses in the team work really well with it. They kind of follow that approach,</p>	<p>Some of my colleagues are interested in what I'm doing. I'm teaching the approach to</p>	<p>16</p> <p>17</p>

<p>“What’s the scaling you’ve been doing with D this week?” And the other one just thinks its airy-fairy and doesn’t believe in it at all but the two that are kind of working alongside me with it, that I’ve spoken quite in depth, “This is what I’m doing, this is why I’m doing it.” Emm, they’re actually starting to use scaling in their work as well and I’m seeing it starting to creep through their wellness plans as well.</p>	<p>other staff.</p>	
<p>We still manage to fit one-to-ones in, even if it’s a ten minute one-to-one, five minute one-to-one, you can still utilise some aspect of the solution approach. Even if you’re on an ob and somebody’s speaking to you; client’s maybe in their room sleeping, somebody’s speaking so you – You can always get it in there, it’s just the language. It’s just normal now to use that kind of language at work. At the minute it’s difficult with the one-to-ones when you’re maybe grabbing five, ten minutes when you’re off and trying to see as many patients in your team as you can because in a five minute slot you can still ask somebody, “Where are you on the scales? What have you done today that’s different?” There’s always some question you can ask, even if it’s just one.</p>	<p>Brief interventions suit the ward environment.</p> <p>It’s about the use of language.</p> <p>You only have time for short interactions.</p>	<p>18</p> <p>19</p> <p>20</p>
<p>Working in part of a team again. Not having, not being in, and this is going to sound silly but not being in control of situations so much because there’s so many patients, so many staff. Things can kick off in an instant. You can be in having a one-to-one with somebody and</p>	<p>The wards can often be quite chaotic.</p>	<p>21</p>

<p>then the alarms are pulled and you're mid, mid-session if you like and that's it blown and you never get back to that point. Because, your mind's gone on something else, the patient's mind's gone on what's going on so you never get back to that point and I've noticed a couple of times it's been at critical times it's happened, just where we were maybe going to get somewhere and start the change process.</p>		
<p>There's the amount of paperwork and having to get it done within set times and that's a nightmare and more and more of our work is getting done on computers so like, the C-Cube where some wards have got all their patients records on computers so, because we're getting everybody's patients at the minute, you're having to go on and read things. It's getting time on there to do it when doctors and the senior staff aren't using the computer it's really difficult to get everything slotted in at times. And patient care, one-to-one, things like that, kind of falls by the way side sometimes. Which really angers me because I didn't get into nursing to do that. I came in to nursing to spend the time with the patients and I find that an inner struggle quite frequently.</p>	<p>Paperwork and time management are the main difficulties in working on a ward setting.</p> <p>I want to spend time with patients.</p>	<p>22</p> <p>23</p>
<p>I don't know. I hadn't a clue what I wanted to do when I left school so I became a hospital cadet, worked in loads of different departments, wards included and wards was the ones that I enjoyed the most. It had lots of people contacts. And I just felt comfortable in</p>	<p>I drifted into nursing.</p> <p>I wanted to understand people better and their experiences.</p>	<p>24</p> <p>25</p>

<p>that role. Emm...and I just wanted to take it further because when you're a cadet you're...when you were a cadet you were less than a nursing assistant but you did the same kind of roles as nursing assistants did. And I didn't want to stay as a nursing assistant, I wanted to know more, understand more, understand why people were the way they were. Or, have an understanding, not understand. And go from there and see what I could learn. I didn't think I was brainy enough to be a nurse because I didn't have enough qualifications for my staffy for a start so I was an enrolled nurse for a long time.</p>		
<p>My Mum's a psychiatric nurse, so I spend a lot of time out at Kingseat, whether it be the knitting group club, drama club, things like that where I was involved with the patients anyway. Going in and out the wards, Christmas parties, so I'd always seen people with mental health issues as people, didn't see their illness, they were just people to me.</p>	<p>I had a family background in nursing.</p> <p>I saw 'people' not 'problems'.</p>	<p>26</p> <p>27</p>
<p>So I know what the cadets were about and knew that it would give me a taste of all kind of work. I was only a cadet for eleven months because of my age when I left school and I worked gardens, kitchen, tally up medical records, occupational therapy, the wards, kitchens, so there's a taste of every kind of job out there going. The laundry, I hated that place. But it gave you a taste of factory work, catering, hospitality, everything like that and it</p>	<p>I was drawn to the caring role inherent in nursing.</p>	<p>28</p>

<p>was the caring side that I wanted to go in to.</p>		
<p>The people contact. It was working alongside people, trying to help them understand themselves I suppose. I mean, it's thirty years since I did that and there's a hell of a lot of changes in mental health nursing now but I suppose when I first started it was very much nurse-medical staff led and the nurses did what the doctors told them to do. But there was always a kind of rebel bitty inside of me that wanted to help the patients to help themselves and I was forever getting in to trouble in my training for talking to patients. "R!" The amount of times I spent in the sluice scrubbing it was unreal because I spoke to the patients. Or in the linen room, putting the stripes on the towels in a straight line because I'd spoke to the patients and had them laughing and joking and..."Too much hilarity whenever you're there, get in that flammin' room and sort out the towels."</p>	<p>I enjoy working with people.</p> <p>I'm a bit of a rebel.</p> <p>I rebelled against the task oriented nursing role.</p> <p>I enjoyed engaging with people not tasks.</p>	<p>29</p> <p>30</p> <p>31</p> <p>32</p>
<p>Well, like I said the cadets was to encourage you in to mental health nursing so we were always encouraged to apply for nursing or some of the girls did medical secretary as well. So, or encourage us to apply so that when we turned seventeen and a half you'd have a training to go to. I didn't have training to start with. I'd actually got a nursing assistant post but there was a big drop out of the class just as I was turning seventeen so I got a phone call when I was on holiday to come back and do my interview and got started a fortnight after I</p>	<p>I drifted into nursing in an opportunistic way.</p> <p>Once I was qualified I was content in my role until my circumstances changed.</p>	<p>33</p> <p>34</p>

<p>finished the cadets. Emm, again in Aberdeen it was general enrolled nursing but you could specialise within your general training to I did mental health. So instead of care of the elderly I did care of the mentally elderly. And my last placement was also in mental health whereas those doing general, did general. And then I got a job two days after I qualified I started as an enrolled nurse and worked for a long time as an enrolled nurse but when my ex and I split up, I was bringing up the boys, there was no progression for us anymore. Nobody was training enrolled nurses anymore, you were stuck. You had very little opportunities getting changes of jobs and everything. So I applied to do the bridging course and got accepted. And that was a struggle but I got there in the end and became a staff nurse in two thousand.</p>		
<p>I suppose it's always been the way I've worked but with doing the solution focused, it gave it a name and it also helped me with the structure and it brought it in to context if you like and it's given me the structure that I'm more confident in doing what I'm doing because it fits the way I work and it allows me to work within this recognised, what is it, evidence based recognised structure if you like.</p>	<p>SFT provided structure to the way I worked.</p> <p>SFT legitimised my practice and my sense of professional identity.</p>	<p>35</p> <p>36</p>
<p>I've done the two solution courses and basically just mandatory stuff. Because we're not getting time off to do it. I've done a bit on voice hearers and motivational interviewing as well. Umm, I did attend a course on THORN but I</p>	<p>I've only done courses fully funded by my organisation.</p>	<p>37</p>

<p>didn't like it, I didn't take it any further.</p>		
<p>And I've had to listen to a lot of CBT, one of my ex-colleagues was a CBT instructor, she would quite often talk about it in the office and I don't like that either. Just, doesn't fit the way I work, my outlook if you like. And though I'm not trained in it and I understand what it's about and the theory behind it and everything, so none of it fitted me as a person because I think what you do has also got to fit you as an individual. Being forced to do CBT or THORN or person centred or something else like that, if it doesn't fit you as an individual you can't, it doesn't work for you.</p>	<p>CBT doesn't fit with my way of being.</p> <p>Therapeutic approaches have to fit with the practitioners way of being and thinking.</p>	<p>38</p> <p>39</p>
<p>It's the assumption that the patient's ready to get well and it goes right back to the beginning of their issues or their childhood and it takes it from there forward whereas that's taking them back to their problem, back to the route where it all started and everything and it doesn't make sense to me to take people back, you're wanting them to move forward.</p>	<p>Change has to be on the patient's terms.</p> <p>Rehashing old problems doesn't help.</p>	<p>40</p> <p>41</p>
<p>So with the solution focused you start from the here and now, you don't look back. You listen to their story and everything and you get that from them but you actually don't do nothing with the story, you take them from where there are now, whereas the CBT, THORN it's always going back, back, back to bring them forward. It's almost like you're knocking them down to build them up again. And I don't like that,</p>	<p>Listening to the patient is important.</p>	<p>42</p>

<p>because they're not the same people they were when the problem started and their perception of the problem at the start is different from what it was when it actually did start.</p>	<p>I believe in recognising patient's strengths.</p> <p>Situations change.</p>	<p>43</p> <p>44</p>
<p>That's how I got, I don't like applying for something unless I've had a taste of it. So, I've had a taste of THORN, I've had a taste of motivational interviewing, various other ones that I can't remember and none of them really suited me as an individual so I was getting pretty disheartened until I did one day, not with yourself, it was with somebody else, on solution, I did two days with them. It was a two day course and a year later your course came up. And that's when I applied for it.</p>	<p>Other courses I've been on didn't 'fit' me.</p> <p>I was searching for something to revitalise my practice.</p>	<p>45</p> <p>46</p>
<p>I suppose because I'd been trained for so long, including me 'en' training, I was getting to be a bit of a dinosaur and I was getting a bit disheartened. Plus working in the community, because I'd only just started working in the community was to give me a more focused, focused approach to my initial interviewing and I remembered that course, the two day taster I'd had and thought 'I enjoyed that. I think that might work for me with this and have this kind of structure and maybe make my treatment plans more appropriate to the individual's needs and it was to make me more modern I suppose, bring me up to date with everybody else that I was working with. Because I did feel a dinosaur.</p>	<p>I was feeling out of touch with current practice.</p> <p>SFBT gave me a more focused way of working.</p> <p>SFBT 'fitted' with who I was.</p> <p>SFBT training made me feel an up-to-date practitioner.</p>	<p>47</p> <p>48</p> <p>49</p> <p>50</p>

<p>S: That's interesting. So it was to bring you up to date and yet, when you did the course, you realised it gave a structure to what you were doing before?</p> <p>D: Yeah.</p>	<p>SFBT gave me a sense of structure to my previous way of working.</p>	<p>51</p>
<p>S: Which means either it didn't bring you up to date, it just gave a name for that or you were up to date to begin with.</p>		
<p>D: I don't know the answer to that one. I don't know the answer to that one. I think it, I was up to date I suppose but I didn't have the evidence based training of it.</p>	<p>I needed to have an evidence-base to my practice.</p>	<p>52</p>
<p>S: Ahh. Right. Okay. So, you were up to date in your practice but you didn't have a title, didn't have a name for it. Sort of, 'just doing what I do.'?</p>		
<p>D: Yeah.</p>		
<p>S: Was it going to cut the mustard?</p>		
<p>D: No.</p>	<p>SFBT gave me the credibility I</p>	<p>53</p>
<p>S: Right, so why was it important to have a name for it?</p>	<p>was looking for.</p>	
<p>D: Because I was feeling like a dinosaur with everybody else that was coming through, the younger folk coming through with their training and had more dynamic and more evidence based names and titles and words if you like where I was still talking year dot</p>		
<p>S: Uh huh. And what was year dot about? What were you talking?</p>		
<p>D: I was just listening to people more than anything, letting them tell their stories, now that's what I would call it but I didn't know that at the time.</p>	<p>Listening to people is important to me.</p>	<p>54</p>

<p>I was just listening to people and asking questions about, “Well, why did you do it that way? What could you have done differently?” Basically, what solution is but I also had a colleague who was very motivated in to people training. And she felt I had to do something as well. And I’m a senior, so doing supervision, clinical supervision, she was kind of questioning what I was doing and wanting me to be able to evidence it. So I thought I liked that solution course so I’ll apply for this one and hopefully that’ll help me.</p>	<p>I am curious about the people I work with.</p> <p>I am a senior member of staff.</p>	<p>55</p> <p>56</p>
<p>It was okay and yeah it was, I did do it in a solution approach and I think it did encourage people to get well but because it didn’t have evidence base behind it, it was a bit flimsy, it’s the only way I can describe it. Whereas now, with doing the course I stand up for what I believe in now and where I am with working with people and it’s made me a lot more confident in that way. But I also did an education slot for a while with the student nurses on solution focused; I did a training session for them at the hospital when they were at their community placements.</p>	<p>My previous way of working lacked a knowledge base.</p> <p>I taught colleagues about SFBT.</p>	<p>57</p> <p>58</p>
<p>Adapting to working in a team again. When you’re working in the community you’re autonomous, you’re lone working, you’ve got your own group of clients whereas on the ward, although you’re in a team, like a consultant’s team, you’re also in the bigger team, you’re in the ward team. So you may have to go on</p>	<p>Wards work on a team basis.</p>	<p>59</p>

<p>other teams to cover if there's nobody on for that consultant team and it's getting used to working with all the different consultants, different staff, particularly when you've got...(whispers), who can be quite difficult to work with but it really has been difficult going back to being in to a team and having to take the backseat and not...the consultant's team's patients aren't mine as such. It's the teams. That's what I found difficult for a while.</p>		
<p>I got a period of time to settle back in to the ward, the ward manager was really good and said, "I'm not going to give you any patients or anything just now, just get used to be being back in a ward environment" because she's quite forward thinking, so she allowed me just to settle in and regularly caught up with me to see how things were going. Because I'd been off for almost six months prior to going to the ward, I was kind of out of things for a wee while. So she gave me that period of time to settle in and I had a mentor as well who, if I was struggling with anything I could discuss things with him. We had a few heated discussions about solution focus because he's very CBT minded but he did see where I was coming from and we kind of worked really well together. So it's good having that support network. We agreed to disagree a lot of things but he wasn't resistant to me trying things my way.</p>	<p>I actively promote SFBT in working with my colleagues.</p>	<p>60</p>
<p>It's frustrating at times. Really frustrating when</p>	<p>The Consultant role varies</p>	<p>61</p>

<p>the consultants don't come down and review their patients. You're left hanging with people wondering if they're going to get a pass at the weekend or not and they're trying to arrange things. The consultant I work with, he's quite laid back a lot of the time. He's quite easy-ozy to let each nurse practice in their own way. He doesn't put restrictions on us or anything, if he thinks something's helping he'll say to you, "Carry on doing that, see where it takes you." So he's quite good. Certain others are a bit more resistive to it although they're coming round a wee bitty.</p>	<p>depending on the individual.</p>	
<p>It's prescription, some of them do prescribe exactly what they want you to do and if you don't do what they want you to do, they're not very happy. Like they expect a member of their team on at all times and they can't understand if one of their team members is obbing another team's patient. They just don't get it which is ridiculous when there's a minimum number of staff on a shift. And you've maybe got three obs and none of them are his patients so "Why are you doing that, you should be looking after our patients" and doing this, that and the next thing, so he gets quite stroppy about that at times.</p>	<p>Consultants often try and prescribe nursing care.</p>	<p>62</p>
<p>It's coming together a lot better now since the new recovery paperwork came in to play at the hospital. I remember writing in my essay we had to do in the first class that we did, and about the three Rs and how solution fitted in</p>	<p>SFBT fits well with the recovery model.</p>	<p>63</p>

<p>with the three Rs and of the lot of the recovery paperwork, solution and recovery works really well. Like I said, my actions plans are quite solution focused and I think although it's not...it's not discussed as it is, a solution approach. The paperwork very much is. It's all aimed at working with the client, the client's the expert, they've got to have an opinion in their care – it's all solution focus approach and everyone else is seeing it as recovery. So, that in the solution in the practice is really, in my eyes, coming together a lot. The clinical side, it's so easy to do it now it's unreal. I don't even think about it so answering some of these questions is making me really think about what I'm doing it's just... Scary. But practising the theory is really kind of amalgamating totally now with the recovery paperwork.</p>	<p>Theory and practice are aligning now in my practice.</p>	<p>64</p>
<p>D: I suppose it's a bit of a shift. Although it's the way I've always kind of worked, I was out of sync with a lot of my colleagues whereas I feel I'm more in sync with a lot of them now. Which is of benefit for the patients.</p> <p>S: Right, is that because you've changed or because your colleagues have changed?</p> <p>D: A combination.</p> <p>S: Good answer. In what way have you changed?</p> <p>D: I've become more self-aware and more aware of what I'm actually doing and more understanding of what I'm doing I suppose.</p> <p>S: Uh huh. What helped you to achieve that?</p> <p>D: Getting structure. Having a name to what I</p>	<p>I've become more aware of how I work since I completed the SFBT course.</p>	<p>65</p>

<p>was doing.</p> <p>S: Okay, and what's helped you colleagues?</p> <p>D: Practising in a recovery approach. Because everybody does it now, that's the way the hospital practises now; it's all the recovery approach with the three Rs coming in to play and the students coming through, they're very much recovery focused and I think it's just kind of solution focused and as I keep saying the recovery process is very closely linked. It's future focused, it's the client working with you, you're not prescribing to the client, it's allowing them to be the expert which in solution we always think that they're the expert, you're they dummy. And I think it's all coming together with that.</p> <p>S: Right and how does that sit then, that shift to sort of recovery focus, how does that sit with CBT and the such like?</p> <p>D: I don't know they can struggle all they want, I get on fine with it.</p>	<p>There has been a wider shift in practice to a recovery approach generally.</p>	<p>66</p>
<p>I get on fine with the recovery model in my approach so I think with the CBT again they seem to think they know what they're doing but after a session of CBT some clients come back really confused as if they've had a psychology appointment for example, "Oh, I've got to practice touching the TV buttons" for a lady with OCD for example and she now sits with the buttons the whole time and can't have anyone else take them off her. "Why do you have to -?"</p> <p>"Oh, it's my homework, it's my homework."</p>	<p>SFBT addresses the whole person</p>	<p>67</p>

Appendix 7

Analysis of Interview: Dawn

Key themes from interview

- Seeing patients as people
- Fit with ontology
- Providing structure
- Epistemological fit
- Partnership with clients
- Use in wards

Provides an epistemological framework to relate ontology to practice

My interpretation of text

- Nurses have to work as part of a team, but I can be a bit of a rebel.
- I value people contact – I want to understand people.
- I drifted into nursing – it allowed me to engage with people and try to help them understand themselves.
- SFT provided me with a structure for doing this in a more formal way.
- SFT gave me a sense of professional credibility and it fitted with what I had previously been trying to do.
- SFT fits with contemporary values-based practice, so it brings me in line current thinking too.

SFT links my ontology with my methodology and brings that in line with contemporary epistemology.

SFT allows me to be part of the team and still a bit of a rebel.

Ontology: I want to help people. I see people as the experts in their own lives. I can't give them answers, I can only help them find answers. I want to engage with people in this process.

Methodology: I listen to people; I see people as people, not 'problems'. I talk with people and try to understand them as people. I didn't have a structure to this before SFT.

Epistemology: Guided by Recovery Model; '3 R's', Tidal Model, WRAP. The application of these ways of seeing people and their problems fits very well with SFT.

Summary

SFT provided an epistemological framework to relate my ontology to practice.

SFT allows me to link my methodology (and ontology) to contemporary nursing epistemology.