

**THE INTRODUCTION OF  
SOLUTION-FOCUSED THERAPY  
TO  
IRISH SOCIAL WORKERS:**

**A CASE STUDY  
OF  
INNOVATION DIFFUSION**

**PhD Thesis  
Department of Social Studies  
Trinity College  
University of Dublin**

**April 2002**

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## **SUMMARY**

The objective of this thesis is to consider how the process of innovation-diffusion occurs in social work when a new practice model is introduced to qualified practitioners.

Taking the form of a case study, the thesis examines the introduction of Solution Focused Therapy (SFT) to Irish practitioners and managers through a large-scale, cross-agency, short course in 1995.

The study set out to address the following questions:

How do social workers engage with, assess and incorporate theoretical innovations into their practice?

What factors influence the processes of engagement with, and evaluation of, innovations in social work?

What is the role of the short training course in this process?

The study explores the influences and processes which shape the individual learning experiences through an in-depth qualitative survey of 52 practitioners 12-18 months after their participation in a specific course. The research population consisted of practitioners and managers with varying levels of experience who were based in child protection, fostering, medical, psychiatric and voluntary service settings. The local context within which research subjects were practising at the time of the study is described and critically analysed.

A range of relevant literature relating to social work practice and theory and therapeutic models of practice and in particular SFT is critically reviewed. The study also considers relevant organisational theories, and theories relating to training, learning and change. A generic framework (Rogers, 1995), which theorises the diffusion of innovation as it occurs on organisational, group and individual levels, has been adopted as a tool to analyse the movement of respondents through the Innovation –Diffusion Process after attending the course.

This thesis demonstrates that a range of inter-related factors, none of which can be taken in isolation, account for both individual and collective innovation-adoption decisions.

Individuals within a social system adopt different roles in relation to the diffusion of an innovation. Product champions, innovators and early adopters play a significant part in the early stages of the diffusion process. The meaning of an innovation to an individual will determine his or her initial attitude towards it. Meaning-making processes occur on both the individual and collective levels.

Social workers who attend courses on practice innovations are especially influenced by two conditions. The first is the degree of choice offered to them in relation to attendance; the second is their felt needs/ problems at the time.

Experimentation is necessary for formal theory to be transformed into *personalised* knowledge (Eraut, 1994) and for practitioners to become confident in assessing 'ideas-only' innovations. An 'ideas-only' innovation will be interpreted and practised in a variety of ways because the practitioner is critical in transforming a theory into a practice.

A combination of environmental and individual factors influences the progress practitioners make with practice innovations in the workplace. Conditions in the workplace and perceived levels of support are environmental factors which influence innovation adoption patterns.

The individual's locus of control, level of self-efficacy and level of confidence are intrapersonal variables of importance in their ability to experiment with innovations. The individual's interpretation of the social work role together with his or her own orientation to practice influences his or her assessment of the practice innovation. For SFT, an *active change-agent* orientation was necessary on the part of the practitioner.

On the basis of these findings, a number of key components in the innovation-diffusion process in social work can be identified and the processes connecting them outlined. These components interact together to create the context and conditions within which, over time, change will either be successfully diffused, will falter or will be rejected or abandoned.

Themes of hope and hopelessness emerged consistently from the accounts of respondents. The importance of the maintenance of hope on the part of workers is reaffirmed in this study. The findings suggest that local agency conditions and team factors contribute towards the development of either hopeful or hopeless contexts of practice.

Post-qualifying courses, such as the one in this case study, can offer practitioners opportunities to develop their skills and to feel more confident in their abilities to help clients. However, courses can have a demoralising effect if practitioners do not succeed in using the innovation effectively. Social workers in the post-qualifying context are still interested in formal theory and in practice models which are of practical use and consonant with their social work ethos. They remain interested in updating and refining their skills in therapeutic practices.



## **DECLARATION**

- a) **This thesis has not been submitted as an exercise for a degree at this or any other University.**
- b) **This thesis is entirely the candidate's work.**

**Signature:**

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**Patricia Walsh**

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## Table of Contents

<b>Declaration</b> .....	<b>ii</b>
<b>Summary</b> .....	<b>iii</b>
<b>Acknowledgements</b> .....	<b>v</b>
<b>List of Tables</b> .....	<b>x</b>
<b>List of Figures</b> .....	<b>xi</b>
<b>Abbreviations</b> .....	<b>xii</b>
<b>Chapter One: Introduction</b> .....	<b>1</b>
<b>The study domain</b> .....	<b>1</b>
<b>Genesis of the study</b> .....	<b>2</b>
<b>Solution Focused Therapy</b> .....	<b>2</b>
<b>Post-qualifying development and education in Social Work</b> .....	<b>3</b>
<b>Rationale for the study</b> .....	<b>5</b>
<b>Social Workers and their use of formal theory</b> .....	<b>5</b>
<b>Aims of the study</b> .....	<b>6</b>
<b>Layout</b> .....	<b>7</b>
<b>Chapter Two: The local setting</b> .....	<b>9</b>
<b>Introduction</b> .....	<b>9</b>
<b>The early development of Irish social work services</b> .....	<b>9</b>
<b>The establishment of Irish community care social work</b> .....	<b>9</b>
<b>The evolution of child protection social work</b> .....	<b>10</b>
<b>Effects of the evolution of child protection social work in the 1990s</b> .....	<b>11</b>
<b>Features of the local context at the time of the study</b> .....	<b>16</b>
<b>Changes demanded of practitioners</b> .....	<b>17</b>
<b>Health Boards and training in the 1990s</b> .....	<b>18</b>
<b>Conclusion</b> .....	<b>20</b>
<b>Chapter Three: Literature Review: Social Work, Theory and Practice</b> .....	<b>22</b>
<b>Introduction</b> .....	<b>22</b>
<b>The social construction of social work</b> .....	<b>22</b>
<b>What is social work?</b> .....	<b>23</b>
<b>Epistemologies of practice</b> .....	<b>27</b>
<b>Typologies and ‘orientations’</b> .....	<b>31</b>
<b>Organisational factors affecting the shape of social work practice</b> .....	<b>33</b>
<b>Individual factors affecting the shape of social work practice</b> .....	<b>39</b>
<b>Cognitive processes and professional expertise</b> .....	<b>45</b>
<b>The process of the development of practice expertise</b> .....	<b>47</b>
<b>The development of professional expertise</b> .....	<b>48</b>
<b>The social work ethos and formal theory</b> .....	<b>51</b>
<b>The politics of theory</b> .....	<b>53</b>
<b>Conclusion</b> .....	<b>54</b>

<b>Chapter Four: Solution Focused Therapy .....</b>	<b>56</b>
<b>Introduction.....</b>	<b>56</b>
<b>(i) Background to the development of Solution Focused Therapy .....</b>	<b>56</b>
<b>(ii) Solution Focused Therapy: .....</b>	<b>65</b>
<b>(iii) Evaluation of Solution Focused Therapy.....</b>	<b>75</b>
<b>(iv) Solution Focused Therapy and Social Work .....</b>	<b>86</b>
<b>Conclusion.....</b>	<b>88</b>
<b>Chapter Five: Continuing professional development.....</b>	<b>90</b>
<b>Introduction.....</b>	<b>90</b>
<b>Part One: Individual, Organisational and Professional Perspectives.....</b>	<b>90</b>
<b>The individual perspective .....</b>	<b>90</b>
<b>The organisational perspective .....</b>	<b>95</b>
<b>Professional perspectives.....</b>	<b>97</b>
<b>The Literature on Training.....</b>	<b>100</b>
<b>Conclusion .....</b>	<b>111</b>
<b>Part 2: Diffusion of Innovation Theory .....</b>	<b>113</b>
<b>Introduction.....</b>	<b>113</b>
<b>Rogers' (1995) Innovation Diffusion Model .....</b>	<b>113</b>
<b>The importance of particular actors .....</b>	<b>117</b>
<b>The role of training in the diffusion of innovation.....</b>	<b>118</b>
<b>The potential of Rogers' model as a framework for analysis .....</b>	<b>118</b>
<b>Chapter Six: Methodological Approach.....</b>	<b>122</b>
<b>Introduction.....</b>	<b>122</b>
<b>Aims of the Research .....</b>	<b>122</b>
<b>A qualitative framework .....</b>	<b>123</b>
<b>Research paradigms .....</b>	<b>123</b>
<b>Using the researcher's own experience.....</b>	<b>125</b>
<b>A case study.....</b>	<b>126</b>
<b>Research design.....</b>	<b>127</b>
<b>The respective roles of practitioner and researcher .....</b>	<b>128</b>
<b>Telephone interviewing.....</b>	<b>129</b>
<b>Advance contact of respondents .....</b>	<b>132</b>
<b>Interview schedule design .....</b>	<b>132</b>
<b>Pilot Study.....</b>	<b>133</b>
<b>Recording of data .....</b>	<b>133</b>
<b>Analysis of data .....</b>	<b>134</b>
<b>Interpretation of the data .....</b>	<b>135</b>
<b>Ethical considerations.....</b>	<b>136</b>
<b>Conclusion .....</b>	<b>138</b>
<b>Chapter Seven: Cross-national diffusion.....</b>	<b>140</b>
<b>SFT: From American family therapy to Irish social work .....</b>	<b>140</b>
<b>The Innovation Development Process .....</b>	<b>140</b>
<b>The specific role of the Brief Therapy Practice (London) .....</b>	<b>145</b>
<b>Diffusion from the UK to Ireland.....</b>	<b>146</b>
<b>The first Irish mass media event .....</b>	<b>147</b>

Impact of the first health board initiative .....	148
Conclusion.....	149
<b>Chapter Eight: ‘The Dublin Course’ – the participants .....</b>	<b>150</b>
<b>Introduction.....</b>	<b>150</b>
<b>The Dublin Course.....</b>	<b>151</b>
<b>Profile of the research subjects.....</b>	<b>153</b>
<b>What prompted individual social workers to attend a course in SFT? .....</b>	<b>157</b>
<b>Stage Two/Three Respondents .....</b>	<b>163</b>
<b>Stage Four Respondents .....</b>	<b>166</b>
<b>Respondents’ evaluation of the short course.....</b>	<b>168</b>
<b>Conclusion.....</b>	<b>168</b>
<b>Chapter Nine: ‘The Dublin Course’ – Interpretations of SFT.....</b>	<b>170</b>
<b>Introduction.....</b>	<b>170</b>
<b>Understanding of the approach .....</b>	<b>170</b>
<b>Appeal of the approach .....</b>	<b>171</b>
<b>Conclusion .....</b>	<b>178</b>
<b>Chapter Ten: After ‘The Dublin course’ – experimentation, conviction and doubt. 180</b>	
<b>Introduction.....</b>	<b>180</b>
<b>Part One: Patterns of Experimentation.....</b>	<b>180</b>
<b>Patterns of Experimentation.....</b>	<b>181</b>
<b>Part Two: Movement of the respondents through the innovation-decision process .</b>	<b>212</b>
<b>Conclusion.....</b>	<b>232</b>
<b>Chapter Eleven: Discussion of Findings: Components and Processes of Innovation</b>	
<b>Diffusion in Social Work .....</b>	<b>234</b>
<b>Introduction.....</b>	<b>234</b>
<b>Components of the Innovation-Decision (Change) Process .....</b>	<b>234</b>
<b>Social work as a site for innovation-diffusion .....</b>	<b>235</b>
<b>The nature of the theory/innovation .....</b>	<b>241</b>
<b>The marketing process .....</b>	<b>248</b>
<b>The means of transmission.....</b>	<b>249</b>
<b>The Transfer Process.....</b>	<b>256</b>
<b>Individual characteristics .....</b>	<b>257</b>
<b>The Sense-making Process .....</b>	<b>265</b>
<b>Environmental Factors .....</b>	<b>267</b>
<b>The Peer Influence Process .....</b>	<b>273</b>
<b>Conclusion.....</b>	<b>274</b>

<b>Chapter Twelve: Conclusions</b> .....	<b>275</b>
<b>Introduction</b> .....	<b>275</b>
<b>Rationale for the study reviewed</b> .....	<b>275</b>
<b>Evaluation of the study</b> .....	<b>277</b>
<b>SFT as a contemporary practice theory</b> .....	<b>280</b>
<b>The Message of Hope</b> .....	<b>281</b>
<b>Do practice models matter?</b> .....	<b>282</b>
<b>Considering change – the role of the training course</b> .....	<b>284</b>
<b>Formal theory and the construction of personalised knowledge – implications for innovation-diffusion</b> .....	<b>285</b>
<b>The complex environment of contemporary social work</b> .....	<b>286</b>
<b>Appendices</b> .....	<b>290</b>
<b>Appendix A – training course notes (Iveson, 1995)</b> .....	<b>290</b>
<b>Appendix B: Research Interview Schedule</b> .....	<b>303</b>
<b>Appendix C – Respondents’ Descriptions of SFT in Summarised Form</b> .....	<b>307</b>
<b>Appendix D: case examples of using SFT</b> .....	<b>309</b>
<b>Appendix E – Respondent Group by setting at time of interview</b> .....	<b>324</b>
<b>Bibliography</b> .....	<b>325</b>
<b>Official Publications and Reports</b> .....	<b>325</b>
<b>References</b> .....	<b>325</b>

## LIST OF TABLES

Table 1: The 35 health board practitioners by setting .....	154
Table 2: The 8 non-health board practitioners by setting .....	155
Table 3: Generic, specialist and therapeutic posts.....	155
Table 4: Total respondent group by setting (N=52) .....	155
Table 5: Length of post-qualification experience (n= 52).....	156
Table 6: Number of Course Participants by Location .....	157
Table 7: Reasons for attending training and stage in innovation-decision process (after Rogers 1995) .....	157
Table 8: Factors influencing decision to ‘seek knowledge’ (N = 37).....	158
Table 9: General levels of recall.....	170
Table 10: Appeal of SFT. ....	171
Table 11: Categories of Appeal of SFT by frequency of mention.....	172
Table 12: Early Rejecters of SFT .....	177
Table 13: Breakdown of Patterns of Experimentation (n= 37).....	181
Table 15: Participants who tried SFT once following training.....	186
Table 16:Child Protection.....	190
Table 17: The 15 ‘returnees’ by agency setting.....	205
Table 18: The rejecters .....	214
Table 19: Profile of the ‘undecideds’ .....	215

## LIST OF FIGURES

Figure 1: Kolb's Learning cycle (1984) .....	92
Figure 2: Rogers' Model of Stages in the Innovation-Decision Process (1995: 163) .....	120
Figure 3: Variables determining the Rate of Adoption of Innovations (Rogers, 1995: 207) .....	121
Figure 4: Timeline: Some key events and dates in the cross-national diffusion of SFT .....	144
Figure 5: Location of respondents in the Innovation-Decision Process at the time of the SFT course (after Rogers, 1995) .....	151
Figure 6: Profile of the research subjects .....	153
Figure 7: Movement of 52 Respondents through Innovation-Decision Process (after Rogers, 1995) .....	213
Figure 8 –The Optional Innovation- Diffusion Process in Social Work. ....	235
Figure 9: The Optional Innovation- Diffusion Process in Social Work, components, processes and specific factors.....	274

## **ABBREVIATIONS**

<b>BASW</b>	British Association of Social Workers
<b>CPD</b>	Continuing Professional Development
<b>EHB</b>	Eastern Health Board
<b>IASW</b>	Irish Association of Social Workers
<b>IFSW</b>	International Federation of Social Workers
<b>MRI</b>	Mental Research Institute, Palo Alto, California
<b>NASW</b>	National Association of Social Workers, USA
<b>NISW</b>	National Institute of Social Work, UK.
<b>SFT</b>	Solution Focused Therapy

## **CHAPTER ONE: INTRODUCTION**

This study is concerned with an attempt to change social work practice by the introduction of a new practice method to Irish practitioners and managers through the medium of a short post-qualifying course. The endeavour was initiated by a small group of social work practitioners and managers who had become interested in the approach. It took the form of an ‘ad hoc’ training event provided for social workers across organisational boundaries.

### **THE STUDY DOMAIN**

This case study is centred on a particular short course in Solution Focused Therapy (SFT) held in Dublin in Oct. 1995. It took place over four days – a 2 day ‘Introductory’ course, followed by a 2 day ‘Advanced’ course. It was attended by 70 social work practitioners and managers. The commissioning agency was the Eastern Health Board; the trainer was a London-based social worker/therapist brought over to Dublin for this one event. The majority of participants came from the health board services, with a small number of non-health board employees attending on a fee-paying basis. This was essentially a ‘in-service’ event, provided by employers for their employees with a trainer who had been ‘bought-in’ for this specific piece of work.

It was the second such large-scale event to be hosted by the local health board and presented by the same external trainer in Dublin. The sequence of events during the early 1990s as SFT made its way into the consciousness of Irish helping professions will be tracked in Chapter Five as an example of the introduction and diffusion of an innovation.

Irish social work in the mid-1990s, and specifically in the Eastern region of the country had particular features and characteristics which created the context and backdrop for the world of social workers at that time. In Chapter 2, these features will be enunciated and analysed to make sense of the context within which the actors in this enterprise were located.

This study aims to address the following questions:

- (i) How do social workers engage with, assess and incorporate theoretical innovations into their practice?
- (ii) What factors influence the processes of engagement with, and evaluation of, innovations in social work?
- (iii) What is the role of the short training course in this process?

The study explores the influences and processes which shape the individual learning experiences across a range of social work settings, through an in-depth qualitative survey of 52 practitioners 12-18 months after their participation in a specific short course. A generic framework (Rogers, 1995) which considers how the diffusion of innovation occurs on organisational, group and individual



levels has been adopted as a tool of analysis and as a base for theoretical triangulation. The study data has been analysed to identify and illustrate significant themes in how social workers incorporate practice innovations, taking the form of a case study into the introduction of one practice method.

### **GENESIS OF THE STUDY**

This study grew out of my own experiences as a social work practitioner and educator over two decades. My completion of professional social work training in Ireland in 1978 was followed by periods of employment in Irish community care social work and English local authority social work in the areas of child welfare and mental health social work. Ten years in practice and numerous short training courses were followed by a postgraduate course in mental health social work with children and families<sup>1</sup> and subsequent family therapy training<sup>2</sup> in London. These experiences reawakened my interest in the relationship between theory and practice and the different forms of knowledge or wisdom which practitioners draw on, develop and construct both in the course of their day-to-day work and developmentally over their years in practice. During my last years of employment as a social work practitioner, I trained in and used Solution Focused Therapy (SFT) in my own work in a family therapy setting in London, and then in a community care 'child protection' setting in Dublin, and latterly in independent and court social work.

My move to the world of social work education in Ireland in the early 1990s coincided with a local developing interest in SFT as an approach for practice, and its introduction to Irish social work practitioners through training courses and texts. As an advocate of SFT myself, I was involved in these developments<sup>3</sup>.

### **SOLUTION FOCUSED THERAPY<sup>4</sup>**

Solution Focused Therapy (SFT) is a particular practice model for the helping professions developed in a family therapy centre in the USA in the 1980s. SFT has been defined as:

... a strategy for encouraging clients to persuade themselves that their lives are not as troubled as they assume. (Miller, 1997: 19)

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<sup>1</sup> The postgraduate diploma in mental health social work with children and families at the Maudsley Hospital, accredited by the University of London in 1988.

<sup>2</sup> The Foundation course in Family Therapy and Part One of the Family Therapy training at the Institute of Family Therapy in London, 1989-1991.

<sup>3</sup> At the same time as embarking on this thesis in Oct. 1995, I was a significant actor in the establishment of training courses on the approach in the local Health Board; collaborated with practitioners to edit a collection of single case studies using the approach (Walsh, 1997); engaged with an academic colleague in providing short training courses on the approach to agencies who requested this; and had already written an article on the approach for an Irish social work journal (Walsh, 1995).

<sup>4</sup> Solution Focused Therapy is also sometimes referred to as Solution Focused Brief Therapy but for the purposes of this study, the more common usage of SFT will be used.

The various contested claims in relation to SFT, its epistemological and theoretical origins and potential usefulness to social workers will be considered further in Chapter Four. It is an approach to change-work which, according to one classification of types of social work, is located on a reflexive-therapeutic axis<sup>5</sup> (Payne, 1997). The approach has been ‘read’ in several different ways:

- some initial formulations considered it to be a cognitive-behaviourist model, which concentrates on achieving specific behavioural and/or cognitive goals with clients on an individual casework level, usually within a specific brief goal or time limited framework;
- others view it as located within a social constructionist view of reality (McNamee & Gergen, 1994);
- others as a existentialist/humanist approach (Payne, 1997).

One of the originators of the approach locates it within a ‘interactional constructivist’ framework (de Shazer *et al.*, 1986). It has been described by one researcher as an approach which:

... directly challenges the fundamental assumptions of most forms of psychotherapy and family therapy by treating clients’ troubles as social constructions. Troubles are, from this perspective, literally talked into existence by clients and others in their social worlds, and can therefore be talked out of existence if clients describe their lives in new ways. (Miller, 1997: 18)

#### **POST-QUALIFYING DEVELOPMENT AND EDUCATION IN SOCIAL WORK**

Post-qualifying courses and events can act both as a catalyst and a significant conduit for the introduction of new concepts, philosophies, theories, practice models and policies into the practice arena. Social workers are, through professional training courses, journals and literature, exhorted to consider themselves as beginning practitioners at the end of their training. They are expected to engage in a process of *continuing professional development* (Adams, Dominelli & Payne, 1998; Compton & Galaway, 1994), which includes the development and refinement of skills, knowledge and practice for generic and specialist social work practice.

SFT was popularised and developed in the Irish context through large and small scale events of short duration in the absence of formal qualification routes or accreditation criteria<sup>6</sup>.

Short courses, in comparison with long courses<sup>7</sup>, are generally intensive, sometimes consisting of a limited number of days ‘training’, or alternatively a short course followed by work-based support

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<sup>5</sup> Reflexive-therapeutic social work seeks ‘the best possible well-being for individuals, groups and communities in society, by promoting and facilitating growth and self-fulfilment. A constant process of interaction with others modifies their ideas and allows them to influence others. This process of mutual influence is what makes social work reflexive. In these ways, people gain power over their own feelings and way of life. Through this personal power, they are enabled to overcome or rise above suffering and disadvantage’ (Payne, 1997: 4).

<sup>6</sup> This is now changing in the UK: The University of Birmingham established a Masters programme in SFT in 2002.

in implementation, either externally or internally provided. An organisation might ‘buy-in’ a trainer or alternatively send employees to externally organised courses. The majority of post-qualifying courses within social services in the UK fit within the parameters of in-service training courses provided by the organisational ‘training unit’ (Howarth & Morrison, 1999). The situation in Ireland was somewhat different at the time of this study.

The term ‘training’ is problematic in the discourse of continuing professional development and education, as it implies a technical-rational<sup>8</sup> model of learning in an organisational environment of agreed and uncontested goals. Smale (1998) has described training as

... a term which often implies, amongst other things, technical expertise to be used by staff *on* ordinary people rather than working *with* them; a neutral value stance where values are being changed; and an absence of political judgements where power and authority relations are an integral issue at stake. (p. 201, original emphasis)

Howe (1986) notes that

Whereas training is an appropriate experience for those carrying out prescribed tasks, professional education suggests that practitioners, acting autonomously, should also be able to enquire and understand the ‘reason why’ of things. (p. 153)

While “training” continues to be the dominant rhetoric in the literature on post-qualifying development, or at least that premised on the work of the ‘training unit’ in a large organisation (Reid & Barrington, 1994), it remains problematic for the reasons outlined above when applied to the fields of social work and social care. In this study the term “post-qualifying *short course*” will be used most of the time<sup>9</sup> instead of “training” in order to include the concepts of continued development and education.

The process connecting my two foci of enquiry (short courses and the diffusion of innovation) is that of the *transfer of learning*. Both in the literature on social work training and practice (Howarth & Morrison, 1999) and the organisational literature on the impact of short courses (Buckley & Caple, 1995), the key process is seen to be in the transfer of learning from short courses to working realities. This study attempts to track such a transfer, by the collection of data sometime after a short course through the self-reports of participants. It contextualises this through the profiles of the participants and the local conditions within which they were working. The general literature on

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<sup>7</sup> ‘Longer courses’ are generally located outside the employing organisations and frequently within academic institutions, often involving the payment of large fees, regular work release, and lasting for at least one academic year.

<sup>8</sup> ‘Technical rationality holds that practitioners are instrumental problem solvers who select technical means best suited to particular purposes’ (Schon, 1987: 3). Furthermore, ‘technical rationality rests on an *objectivist* view of the relation of the knowing practitioner to the reality he knows. On this view, facts are what they are, and the truth of beliefs is strictly testable by reference to them. All meaningful disagreements are resolvable, at least in principle, by reference to the facts. And professional knowledge rests on a foundation of facts’ (Schon, 1987: 36).

<sup>9</sup> The exception will be when referring to training literature.

training, learning theories, and the specific social work and social care literature on training and development are reviewed in Chapter Five.

### **RATIONALE FOR THE STUDY**

While SFT has been considered by its advocates as an innovation, as something ‘new’ and ‘different’, its status as an innovation as perceived by a particular professional group, had not been tested empirically prior to this study.

Although one study had considered its effectiveness as a social work tool in Finland (Sundman, 1997), and another text has developed a hybrid of SFT (de Shazer *et al.*, 1986) and Narrative therapy (White & Epston, 1990) into a model for Constructive Social Work (Parton & O’Byrne, 2000), no studies have been published which consider how social workers view and understand this approach; whether it has an appeal to them or not; whether it appears more applicable in some settings than in others; and (most importantly) how they fare when they try to use the approach in practice.

As no research had been carried out on the perceptions of SFT held by Irish social workers<sup>10</sup> or on the impact of the SFT short courses that were becoming popular both in Ireland and in the UK, I was keen as an educator/researcher to address this gap in knowledge. Of related interest was the question of the impact of short courses over time and their role in the diffusion of practice innovations.

The assessment of SFT by a large cohort of social workers across a range of settings could also illuminate whether social workers in the Irish context accept therapeutic interventions as part of their social work tasks, and if so, how central they are in the practice of social work.

The particular Irish context within which social workers were practising and within which this short course took place will be described in Chapter Two.

### **SOCIAL WORKERS AND THEIR USE OF FORMAL<sup>11</sup> THEORY**

Studies of the effectiveness or applicability of social work practice methods (Goldberg *et al.*, 1985; McDonald & Sheldon, 1992) have tended to be focused on the gathering and analysis of primarily quantitative data. This traditional scientific approach has the disadvantage of taking for granted ‘the

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<sup>10</sup> The only study I was able to locate which had followed up the participants of SFT training was an American one focused on which techniques they had adopted, collecting information through postal questionnaires (Skidmore, 1997).

<sup>11</sup> A distinction is being made here between ‘practice theory’, knowledge derived from practice experience and ‘formal’ theory, that which is derived primarily from books and formal teaching, and applied deductively in practice.

methodology and basic assumptions of the scientific method in generating these results' (Payne, 1997: 288). Large scale in-depth studies into the practice of social work (DHSS, 1978; Crousaz, 1981), practitioners' use of theory (Curnock & Hardiker, 1979; Secker, 1993) and the development of professional, (Eraut, 1994) and specifically, social work expertise (Harrison, 1991; Hindmarsh, 1992, Fook *et al.*, 2000) have confirmed the inadequacy of a positivist, technical rational approach for exploring and analysing practitioners' use of formal theory and their development of 'personalised knowledge' (Eraut, 1994). Newer epistemologies of practice centred on the notion of the 'reflective practitioner' (Schon, 1983; 1987; Gould & Taylor, 1996) have reformulated the practitioner's position as that of an active researcher, creating theories for individual cases, as practice experiences inform thinking. However, these newer theories also have some shortcomings.

Not all short courses are concerned with the introduction of practice innovations but those which are, and the role of such courses in the diffusion of practice innovations, have been relatively under-researched in the field of social work. The classic task-centred studies of the 1970s (Reid & Epstein, 1972; Goldberg, Gibbons & Sinclair, 1985) focused on the *outcomes* of the application of a specific model; they did not explore practitioners' perceptions of the approach or their translation of it from training course to work practice.

The nature of social work, studies into the practice of social work, the use of formal theory by social workers, and newer epistemologies of practice will be reviewed in Chapter Three.

#### **AIMS OF THE STUDY**

This study seeks to complement existing studies in the development of knowledge about how social workers process practice innovations. It takes participants at one specific short course in SFT as the research subjects, employs a qualitative research framework and adopts an interpretative/constructionist research paradigm. The methodology will be discussed in Chapter Six.

An innovation is an idea, practice, or object that is perceived as new by an individual or other unit of adoption. It matters little, as far as human behaviour is concerned, whether or not an idea is 'objectively' new as measured by the lapse of time since its first use or discovery. The perceived newness of the idea for the individual determines his or her reaction to it. If the idea seems new to the individual, it is an innovation. (Rogers, 1995: 11)

Rogers' innovation-diffusion theory has been used as an analytical tool to evaluate the impact of a cross-organisational training course, which had lateral peer-group rather than hierarchical management support. My review of the general and social work specific training literature indicated that no other tools were in operation which fit the complexity of such an endeavour.

Rogers' theory is described and reviewed in Part Two of Chapter Five. In Chapter Seven, the theory is drawn on to illustrate how SFT was diffused from American family therapy to Irish social work.

My initial research questions focused on the impact of the training on participants and sought to assess this quite narrowly. However, as data collection and analysis progressed, it became evident that the research interviews had created an opportunity for the social work interviewees to reflect upon and develop their own views about the nature of the social work enterprise, the impact of formal theory (such as practice models) on their practice and other factors which they saw as critical to their day-to-day practices: in short, the respondents in this study were theorising their practice through the interviews. Subsequently my research questions were reformulated:

- 1) What can be learnt from this study about the relevance to social workers of short post-qualifying courses on formal theories such as SFT?
- 2) How do social workers make sense of and incorporate theoretical innovations into their practice in the post-qualifying environment?
- 3) What can be learnt about the different factors at individual, team and organisational levels, and the interplay between such factors, which influences engagement with, and evaluation of, innovations in social work?

## **LAYOUT**

To recap, the study is divided into twelve Chapters.

Chapters One to Six deal with the context of the case study.

In Chapter Two, the context of the study, that of Irish social work in the Dublin area in the mid-1990s is described.

The Literature Review consists of three chapters, Three to Five inclusively. Chapter Three considers the nature of social work and its defining components and examines and assesses studies on social work practice, practitioners' use of theory and epistemologies of practice.

In Chapter Four, the origins of SFT are outlined, the model itself is explained and SFT research studies and critiques reviewed.

In Chapter Five, Part One reviews the literature on organisational training and organisational change and theories of learning in so far as they are relevant to my study. The literature on social work/social care training and development is examined and key issues discussed. In Part Two of Chapter Five, Rogers' theory on Diffusion of Innovation is outlined.

Chapter Six details the methodological framework of the study.

In Chapters Seven to Ten, the case study on 'The Dublin Course' is presented.

The Dublin short course is firstly contextualised through a description of some of the significant events leading to the cross-national diffusion of SFT into the Irish social work world in Chapter Seven.

Chapters Eight, Nine and Ten contain the central findings of the study.

Chapter Eight provides a profile of the research subjects, an overview of the 'prior conditions' leading subjects to attend the short course and their evaluation of the course itself.

Chapter Nine outlines the research subjects' perceptions of SFT and an analysis of the level and types of appeal SFT had.

Part One of Chapter Ten maps the subjects in relation to their positions in the innovation-decision process at the time of attending the short course and describes their intentions and efforts to use SFT after the course. Part Two maps and then analyses their movement through the innovation-decision process between the time of the course and the study one year later, identifying both the individual and environmental factors which had an bearing on their progress.

Chapters Eleven and Twelve provide the discussion and concluding sections of the thesis.

Chapter Eleven provides a discussion of the findings of the study and reviews these in relation to existing literature. A map of the innovation-decision process is proposed and described, and its component parts and processes are analysed.

Chapter Twelve draws the study to a conclusion and considers the wider implications of the findings of my study.

## **CHAPTER TWO: THE LOCAL SETTING**

To understand and interpret case studies, researchers describe the context in detail.  
(Gilgun, 1994a: 375)

### **INTRODUCTION**

This chapter provides a detailed picture of the employment context within which this study is located – namely the world of Irish social work practitioners in the Eastern Health Board region<sup>12</sup> in the mid-1990s.

### **THE EARLY DEVELOPMENT OF IRISH SOCIAL WORK SERVICES**

Historical accounts (Gilligan, 1991; Skehill, 1999) have noted that the early development of social work in Ireland took place primarily within medical settings through the appointment of almoners. Voluntary bodies played a major role in the development of social services in Ireland from the beginning of the twentieth century:

In the past, it was the religious orders or Protestant voluntary committees that ran schools for the poor, orphanages and hospitals. Organisations such as the ISPCC<sup>13</sup> acted to protect children from neglect and violence. Societies such as the St. Vincent de Paul sought to provide some kind of financial safety net to poor families. (Gilligan, 1991: 143)

Until the beginning of the 1970s, the numbers of social workers employed in Ireland remained minimal, with the majority employed in medical, psychiatric or voluntary settings (Skehill, 1999).

The development of Irish social work services entered a new phase in the late 1960s and early 1970s, coming under the direct influence of the State for the first time when social workers were appointed to the probation service in 1969, and then to the newly established health board structure of community health and welfare provision in 1974. This expansion of social work posts within statutory services is reported to have been coupled with a diminishment of the role of voluntary (or non-statutory) agencies as direct employers of social workers (Gilligan, 1991).

### **THE ESTABLISHMENT OF IRISH COMMUNITY CARE SOCIAL WORK**

The 1970 Health Act provided for the establishment of eight Regional Health Boards divided into three ‘programmes’, catering for general medical, ‘special’ medical and community care services. While the Act did not make specific provision for a social work service, one was subsequently established within the community care teams, linking health and social services at the point of

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<sup>12</sup> The Eastern Health Board is one of eight regional health boards in the Republic of Ireland providing health and social services on a geographic basis. The Eastern Health Board covers the counties of Wicklow and Kildare and the city and county of Dublin.

<sup>13</sup> Formerly known as the Royal Society for the Prevention of Cruelty to Children (RSPCC).



delivery (Dept. of Health, 1985). The creation of the social work service headed by a medical Director of Community Care was not without its problems and Butler (1996) notes that during the 1980s a vigorous but unsuccessful campaign was fought to establish an administratively separate social work service which would protect professional autonomy.

The community care programme aimed to provide a unified health and welfare service on a countrywide basis. Whilst social workers were employed in all three programmes, it was within the community care programme that a significant expansion in the number of social workers employed occurred in the 1970s<sup>14</sup>.

Irish community care social work was originally envisaged as a broadly based service for three particular groups: the elderly, the disabled and families with young children but from the mid-1970s social work with children and families became its primary focus (Dept. of Health, 1985).

By the mid-1980s, although there was a sizeable number of social workers employed within the community care service and smaller numbers in medical, psychiatric and voluntary settings<sup>15</sup>, the service in all areas was viewed as inadequate and in need of expansion (Department of Health (Ire.), 1985). Embargoes on public spending during the 1980s ensured that the social work field remained static in terms of numbers employed until change came with improved economic conditions and raised public concerns about social problems towards the end of the 1980s.

The social work service within the community care structure consisted, until the early 1990s, of two grades: social work practitioners and senior social work managers, accountable to the medical Directors of Community Care in each local area.

The Eastern Health Board was the largest of the eight health boards and the biggest employer of social workers in the country. At the time of this study, it was divided into ten geographical areas, numbered one to ten, covering Dublin city and county, Wicklow and Kildare.

#### **THE EVOLUTION OF CHILD PROTECTION SOCIAL WORK**

During the 1980s, prioritising of work with children and families, to the neglect of a more generic role, continued within community care social work, and a further restriction emerged in the type of cases considered most in need of a service:

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<sup>14</sup> Skehill (1999) notes that the number of social workers employed in the Eastern Health Board region rose from 3 in 1974/5 to 41 social workers and 9 senior social workers by 1976.

<sup>15</sup> In the mid-1980s, there were estimated to be approximately 300 social workers employed by health boards in community care social work; 90 medical social workers, 36 psychiatric social workers; and a smaller number of mainly single-handed posts in voluntary organisations in learning disability and physical disability fields (Department of Health, 1985).

Social work in community care is a frontline service which aims to provide a locally based facility for people who need help with social problems (p. 27) ... [ but] in most areas the service is confined to families and child care ... in some areas this focus has been further concentrated on families with children at risk. (Dept. of Health, 1985: 59)

Over the three decades from 1970 the terms 'child abuse' and 'child protection' have 'gained increasing currency on the Irish public and political agenda, reinforced from time to time by highly publicised events' (Buckley, 1999: 21), and this contributed to the increasing focus on incidents of abuse and neglect in community care social work.

However, the emergence of 'child protection' as a distinct form of social work practice can be dated more recently, and was, I contend, imported into the Irish context from our UK neighbours in the late 1980s and early 1990s (Walsh, 1999), fuelled not only by specific highly publicised events but also by the activities of key actors and professional groups for whom it was a domain of especial interest. That social workers were also actors in this process must be acknowledged.

Whilst a number of high profile Inquiries into individual cases of serious child abuse (Dept. of Health (Ire.), 1993; Keenan, 1996) resulted in 'unprecedented public and political attention on child protection policies and practices' (Ferguson, 1996: 5) 'child protection' and the notion of a 'child protection system' became established through specific Irish publications (Ferguson, 1993; 1994; 1995a; 1995b; Buckley, 1996), the establishment of postgraduate courses in Child Protection and Welfare in two Irish universities in the early 1990s<sup>16</sup>, and the first large-scale commissioned research studies into the working of the 'child protection system' in the mid-1990s (Buckley *et al.*, 1997; Ferguson & O'Reilly, 2001)<sup>17</sup>.

These developments took place within a context of increased public and political scrutiny of child welfare services, and the reframing of child welfare work into child protection work created both additional tensions and opportunities within the field of social work.

## **EFFECTS OF THE EVOLUTION OF CHILD PROTECTION SOCIAL WORK IN THE 1990S**

### **Legislation**

The Child Care Act, 1991, was implemented in the period 1994-1996. Implementation was hastened in response to the high-profile Kilkenny case and the subsequent publication of the first Irish inquiry into the role of the state in child welfare (Dept. of Health (Ire.), 1993).

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<sup>16</sup> The postgraduate courses and specialisation by academics in child protection also led to an increase both in publications and research studies into Child Protection and Welfare by postgraduate students (Buckley, 2002).

<sup>17</sup> Ferguson (1996) quotes Parton (1991) as noting that the term 'child protection' is of relatively recent coinage in the *official* language of social policy and practice, but to assume that the term was somehow known professionally or accepted professionally outside of official discourses, would be misleading.

This legislation had the potential to fundamentally alter the shape of services for vulnerable children and their families, as for the first time it introduced into Irish legislation the requirement that the delegated authorities (the health boards) should *promote* the welfare of children in need of services as well as *safeguard* those who needed protection. Yet, research indicates that safeguarding activities accounted for over 81% of the budget for child care services compared to 19% for promotional activities in the EHB area in the mid-1990s<sup>18</sup>. A study in another Irish health board at the same time found that ‘much of the time and energy of those charged with promoting the welfare of children has been directed into a more narrowly focused *child protection* framework’ (Buckley *et al.*, 1997: 18, original emphasis).

Social workers on the ground were found to be predominately occupied with the investigation and management of cases of suspected child abuse and neglect. The filtering of such cases through a narrow ‘child protection’ lens at the expense of a broader role in promotional, preventative and therapeutic activities was a phenomenon which has also been identified in the UK system some years previously (Howe, 1992).

#### **Additional resources**

The provision of additional resources to implement the Child Care Act of 1991 led to a period of expansion from the mid-1990s, which consisted not only of an increase in social work posts within the health board community care services, but also to an increase in posts in related social professions<sup>19</sup>. The increasing number of ‘frontline’ posts was filled primarily by newly-qualified social workers (NSWQB, 2000). Even with a sustained expansion of social work posts over 7 years, the level of social work provision per head of population in Ireland was found in 1999 to be amongst the lowest of the industrialised countries and less than 50% of the level offered within the UK<sup>20</sup>. This staffing level raised serious questions about what may be expected from a social work service.

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<sup>18</sup> *Safeguarding* activities were identified as those which targeted: child protection, provision of alternative family and residential care and child psychiatry services; and on a universal level: child abuse and accident prevention programmes; and health education on drugs and alcohol. *Promotional* activities included: counselling, child care, families and parenting groups; and on a universal level: family resource centres, nurseries and community mother schemes.

<sup>19</sup> By 1999, it was estimated that the Department of Health and Children was the ‘parent’ department for 83.3% of the total number of 1,390 social work posts established in the country, with the majority of posts (58.6%) located in health boards. 1996 Census figures are reported to have shown an increase in the numbers of related professions in the mid-1990s, and ‘In Child Care, Youth and Community Work and Social Care, there has been a dynamic expansion, not only in relation to numbers of students and courses but also new specialisms (e.g. Community Childcare worker, Early years worker, Play worker) and new levels of qualifications’ (NSWQB, 2000: 12)

<sup>20</sup> An international comparison carried out by the NSWQB in 1999 indicates that in Ireland there is one social work post per 2608 persons, compared to a figure of one social work post per 1106 persons in the UK, relating to local authority social workers only (NSWQB, 2000: 11).

The introduction of new specialisms, such as the community care psychologist and childcare worker working alongside or within social work teams, also challenged the nature of the social work task and role definition for community care social workers, offering as it did alternative opportunities for therapeutically-oriented work and generic family support work to be carried out by non social work professionals.

### **The impact of expansion**

The expansion of the child welfare service resulted also in the introduction of new levels of community care management, with a team leader grade introduced in the early 1990s. Although there has been a ‘major growth in the managerial component in child protection work’ (Buckley, 1999: 22) with increased attention paid to the introduction of protocols and procedures, it can be argued that community care social work remained chronically under-managed and supported. The slow development of team leader posts within community care social work, the expansion of team leader responsibilities and duties in relation to the extension of locally-provided residential facilities and so-called ‘special arrangements’ for individual children<sup>21</sup>; increases in the numbers of child welfare cases in court, and the introduction of child care workers into social work teams, created a situation where some practitioners received less rather than more supervision, support (and surveillance) for their work. Ratios of team leaders to supervisees (social workers and child care workers) appear to have been in the region of 1-15 in the mid-1990s.

New procedures were introduced in the 1990s, the most notable of which was recommended by the Kilkenny Incest Case report (Dept. of Health (Ire.) 1993) and made it a requirement for Health Boards and the Gardaí to share information in cases of suspected child abuse and neglect (Dept. of Health, 1995). Buckley has warned about the dangers of an over-reliance on protocols and procedures based on the assumption that child maltreatment is predictable and therefore preventable, as

... failure to reach this goal renders the practitioners charged with statutory obligations in child protection seriously culpable, and creates a tension between front-line workers and their official agency function. (Buckley, 1999: 22)

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<sup>21</sup> The term ‘special arrangement’ ‘Describes provision for a child or children in the care of the health board which is neither foster care or an already established children’s residential centre ... usually arises from one of four reasons: i) in response to a high court order stating that the child is to be kept in a secure placement and the health board is unable to locate such a placement; ii) as an emergency response to a child in its care for whom no placement could be found; iii) as a planned placement for a child with unique difficulties, following a comprehensive assessment, and iv) a family group of brothers and sisters, in need of care and whose interests are served if they remain together, sometimes within the family home.

... This type of children’s service is a matter of concern. First, it indicates a lack of planning and provision, as the board finds itself without suitable placements for vulnerable young people. *Consequently, the time and energy of senior managers and staff is focused on developing individual short-term solutions.*’ (SSI, 2001: 13, my emphasis)

The effect of this new protocol for social workers was profound because it reinforced both their role in, and perception of them (by clients and others) as agents of, social control and regulation. Other protocols and managerial structures and bodies have been proposed since 1995-1997 but have stalled because of continuing staffing crises. The most significant of these, the 1999 Children First, new national child protection and welfare guidelines are not yet fully implemented in the EHB region because of staffing shortages and training delays.

### **Public scrutiny**

The extent to which social workers are mindful of, and possibly organised by, fear of censure and public criticism in child protection work, has been documented both in the UK and Ireland (Howe, 1992; Buckley, 1999). In Ireland in the mid-1990s, a study into child protection practices in one Eastern Health Board area office found that the

... social workers in this study ... felt caught between the public perception attached to their role, and the reality of day-to-day practice. Practitioners felt that their work was being driven by 'politicians and the media'. (Buckley, 1999: 36)

The impact of this fear of censure is thought to lead to a form of defensive practice, and intense anxiety on the part of those charged with child protection responsibilities, which in itself stifles the ability to reflect on and consider the impact of particular actions:

... the climate of professional impotence and defensiveness attenuates our capacity for self-examination, which in turn feeds our helplessness and increases our anxiety. It is harder to stand outside and evaluate with a fresh eye, (Cooper, 1999: 102)

Practitioners and their managers in such situations may be less likely to grapple with the uncertainties and complexities inherent in child welfare work, and, instead of considering alternatives to substitute care for a child deemed to be at risk of harm, prefer the safer option of removal, mindful that 'all that the wary social worker and her supervisor have to do if blame is to be avoided is "go by the book"' (Howe, 1992: 507).

### **Child Protection social work and anxiety**

Fear of censure can be one source of anxiety for practitioners in the child protection field, but another source of anxiety is the nature of the work itself. Drawing on psychoanalytical theory, Menzies (1959) produced a classic study of the functioning of the nursing service in a general hospital, in which she demonstrated how social systems became organised in the nursing service as an externalised defence against internal anxiety triggered by the nature of the nursing task. Her work and that of other theorists such as Jacques (1955) and Mattinson and Sinclair (1979), have been developed and applied to professional-familial dynamics in child psychiatry (Britton, 1981), in staff supervision (Hughes & Pengelly, 1997), in child protection (Cooper, 1999), and interagency collaboration (Woodhouse & Pengelly, 1991). Systemic analyses have also identified patterns of communication between professionals themselves and between professionals and families which can unwittingly replicate (or react to) disturbed behaviours and patterns of

communication within client families (and professional systems) (Reder, 1986; Reder, Duncan & Gray, 1993; Dare *et al.*, 1990). Whilst the splitting of the child protection task between a number of professional individuals and agencies can lead to confusion about roles and boundaries, it is also maintained that

... in the case of child abuse, it is primarily the nature of the problem that activates a large network of statutory and other workers who are deemed relevant to its solution. (Reder, Duncan & Gray, 1993: 68)

Such networks can become 'problem-determined systems' if the necessary resources and structures are not provided for workers in child protection. Reder *et al.* (1993) identify the need for a 'secure work setting'<sup>22</sup> to minimise dysfunctional professional systems. Hughes and Pengelly (1997) identify anxiety-laden dynamics which can occur when 'worker, supervisor and the agency as a whole are being bombarded by the impact of emotional issues arising from certain sorts of work that occupy most of their time and energy' (p. 92). They suggest that

... agencies where the task is entirely concerned with human 'raw material', where the main technical resource consists of the staff themselves and where the work must be carried out predominately via relationships with service-users, are especially prone to be affected by specific anxieties stirred up by the work, and by the staff's need to defend against them. (p. 119)

The impact of uncontained anxiety and unconscious fantasies on child protection workers (and others in health and mental health services) is borne out by the findings of Woodhouse and Pengelly (1991) and Cooper (1999). The former note that social services departments sometimes behave like 'citadels under siege' where

The boundaries of social work – within which social workers should be sure of their distinctive role and competence, and across which they receive a public mandate and are in turn publicly accountable – have resembled a war zone more than a workable frontier. (p. 175)

In social services departments focused on child protection work, they found that fear of failure (and censure) not only came from without:

... we discovered that social workers needed no external accusers. They were the first to blame themselves, often in anticipation. Their professional self-esteem was undermined not only from outside but from within, by anxiety that they might be perpetrating the very failures of parenting which they were committed to making good. (Woodhouse & Pengelly, 1991: 177)

Cooper's comparison of the nature and forms of anxiety in the French and English child protection systems highlights the role of the judiciary in either containing or diffusing anxiety through the more or less active role played by Judges in the different systems. He concludes that

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<sup>22</sup> 'Many factors contribute to a secure setting, including adequate training, regular supervision and support, clear procedural guidelines, adequate funding and staffing, low staff turnover, an optimal caseload, continuity in management, a stable organisational structure, good secretarial back-up, requisite facilities and so on. All these elements combine to provide the mechanical means for effective communication and also a context within which the workers feel valued, respected and supported.' (p. 69)

... the structural relationship between the social work and legal parts of the English system does not readily enable child protection workers to manage their own authority; authority is too easily experienced as destructiveness ... social workers deserve, and need, to be protected from external blame; the potential for self-blame and guilt, transferred from and activated by the families themselves, is already great enough. (p. 113)

### **Staffing and workloads**

By the mid-1990s, there were indications that the community care social work service in the Eastern Health Board region was under severe strain, resulting in an increase in the number of staff resignations<sup>23</sup> and threatened industrial action.

The threat of industrial action triggered an external review (EHB/Impact, 1997) of the region's child care and family support services, a review which not only identified factors contributing to the strain<sup>24</sup> but which also outlined the nature of the 'strain'<sup>25</sup>. This review also produced a profile of services within the region which challenged assumptions that the ten local community care areas comprising the EHB region were 'dancing to the same tune'. Instead this review illustrated firstly: the extent to which social workers in the different areas were interpreting their responsibilities and defining priorities according to individual and collective team perceptions of need; and secondly that the practice realities within which individuals worked differed greatly in the sense of pressure of workload perceived, the perceived focus of the service and the emphasis placed on child protection versus a broader child welfare remit (EHB/Impact, 1997).

### **FEATURES OF THE LOCAL CONTEXT AT THE TIME OF THE STUDY**

At the time that this study was conducted, local practitioners were operating in a field of practice that was becoming increasingly dominated by concerns regarding child abuse and child protection. Recent Irish Inquiries into high profile cases had held both health boards and their social workers to

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<sup>23</sup> Fulham (1997) in a study on staff retention problems in one community care area found that factors influencing the decision to resign included 'high stress levels, unmanageable case loads, and a lack of resources such as placements for children in need of care', and that the majority of respondents in this small study 'received no induction training and all were allocated a case load within the first week'.

<sup>24</sup> Factors identified were: new and additional responsibilities arising from the Child Care Act, 1991, and other new legislation in the arenas of adoption and domestic violence; the increase in the demand for child protection services arising from increased public awareness of the issue and a preparedness to report incidents or concerns of abuse; increases in demand and complexity of work with adolescents where drug use was an issue; failures in planning which had produced large discrepancies in the numbers of social workers trained and the staffing requirements of employers; and the reduction in the commitment of independent voluntary and religious bodies to provide residential care for children and young people (EHB/Impact, 1997).

<sup>25</sup> These strains were identified as: 'a crisis in staff morale which has led to threats of, and actual industrial action; a crisis in the availability of placements for children which leads to the possibility that children who are assessed as requiring care may be left in situations of high risk because few, if any, placements are available; a service which is 'crisis-driven' at all levels from senior management to social workers who are responding to the immediate crisis case with little opportunity for planned individual work or strategic preventative or promotional work; a hostile press and public comment [which] is an added pressure on the whole situation' (EHB/Impact, 1997: vii).

account for past failures to protect children. New legislation was being enacted which placed additional responsibilities on health boards in the areas of child welfare, adoption and domestic violence. Area teams were expanding, practitioners were being promoted into management positions or leaving the service, and there was an increase in the number of newly qualified workers who were operating the frontline child protection system. As posts increased, so also did vacancies. As public awareness of child abuse grew, the number of referrals received by health board offices increased. Waiting lists were introduced in some areas to reduce the pressure of high caseloads on individual workers. Local reorganisations included the introduction of intake systems in some areas and tiered levels of management. This redefining of the community care social work service as part of a child protection system, and the expansion of child care and family support services and social work posts within the community care structure created both opportunities and strains for those working within the system.

#### **CHANGES DEMANDED OF PRACTITIONERS**

The contextual features outlined above also challenged social workers to question the nature of their role and the type of work they could carry out. Howe argues that the establishment of a discourse of 'child protection' redefines the roles that the various actors have to play:

Social workers would have to become investigators and not family caseworkers. Managers would have to become designers of surveillance systems and not casework consultants. Parents would have to become objects of inquiry whose behaviour could be predicted and not people whose skills could be improved. The shift is from therapy and welfare to surveillance and control. (Howe, 1992: 497)

Two particular aspects of practice which were apparent in this location at the time of the study were:

the increasingly explicit regulatory role which social workers were expected to undertake; and the increase in referrals to health boards and the numbers of cases or families awaiting a service on waiting lists.

The introduction of protocols such as those on the reporting of cases of suspected abuse and neglect between the health boards and the Gardaí, increased public and political expectations and scrutiny of child welfare services, and prioritising investigation of suspected cases of child maltreatment, have all served to make explicit the regulatory nature of much social work practice and to emphasise this aspect of practice at the expense of the more traditional enabling or helping role. Social workers in the health board were being redefined as child protection workers with an explicit social control function, which had been present but minimised in many official accounts of social work under previous conditions (Skehill, 1999), to which many established workers did not actively subscribe. The extent to which workers were equipped for this change in emphasis is



questionable given that most traditional theories of helping are premised on a functionalist approach to practice (Howe, 1987) and based on a consensus model of society<sup>26</sup>.

Social work caseloads and referral rates to services continued to escalate throughout the first part of the 1990s, demanding change in patterns of response and creating pressure to undertake work which would be short-term and limited in focus. Many traditional practice theories<sup>27</sup> are not brief methods of intervention, and the practitioners were not necessarily trained to adapt to these changing conditions. Thus the advent of a training event in a 'brief' method of therapy was likely to be met with mixed reactions.

The introduction of a practice innovation which apparently offered a brief therapeutically-focused intervention was particularly timely, given the need for practitioners and service managers to consider short-term methods of intervention within community care social work, in a context of being increasingly uncomfortable with a more overt social control function. Yet, a question of some importance in these changing conditions, and one which is pertinent to the introduction of a particular practice method with a 'therapeutic' label is whether the social work actors employed in the newly-defined child protection system saw themselves as still occupying a therapeutic role in their work or whether this had been abandoned in the new conditions which prevailed.

For practitioners and managers outside the community care structure, located in medical, psychiatric or voluntary settings, the events of the early 1990s were somewhat demoralising.

Firstly social work as a field of practice was in danger of becoming synonymous with child protection (Walsh, 1999), leading to neglected areas of practice and lower visibility and possibly lower status for those occupying other social work posts. Secondly the Department of Health was renamed the Department of Health and Children, emphasising the priority given to this client group at the expense of a broader Personal Social Services remit. Thirdly resources were concentrated in the field of child care, arguably at the expense of other equally needy client groups and services.

## **HEALTH BOARDS AND TRAINING IN THE 1990S**

### **(a) The Health Board as a 'learning organisation'**

A small-scale analysis of Irish Health Boards was undertaken in 1995 which examined the extent to which they were operating as '*a learning organisation*'<sup>28</sup> (Joyce & Kenefick, 1997). While it was

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<sup>26</sup> However, when one examines the historical literature on casework, it is evident that 'the use of authority' was a much-debated concept both in the USA and the UK from the inception of public welfare services (Brown, 1966; Studt, 1966).

<sup>27</sup> With the notable exceptions of crisis-intervention and task-centred casework.

<sup>28</sup> A 'learning organisation' is one which engages in five disciplines: promoting personal mastery; building a shared vision; examining mental maps through reflection and inquiry; collective team learning; and systems thinking focused on integration and cohesiveness.

limited to an examination of management activity within different sections of health boards nationally, the conclusion was that health boards fall far short of the ideal of a 'learning organisation'. While acknowledging the complex multi-disciplinary nature of many of the activities engaged in, Joyce and Kenefick (1997) were critical of the culture within the boards, and identified some significant barriers to a learning environment:

The clearest message is that there is a need for more reflective practice within the health service. Often mental models are not recognised, much less discussed or challenged. Staff tend not to receive constructive feedback on either good or poor performance. Hierarchical structures and tribal boxes militate against systems thinking. Staff need to be enabled and encouraged to reflect on both their good work and their mistakes. There is a need to develop a climate that is supportive and to ensure that managers listen to and support their staff. (Joyce & Kenefick, 1997: 59-60)

If 'learning organisations' offer optimum conditions for continued development, then health boards were offering far less than ideal conditions. Yet the authors also noted positive incidents related to team learning:

... situations in which training or learning events on particular topics had been organised by the staff themselves either for their own staff and colleagues or for a multidisciplinary group across the board all of whom had a role to play in dealing with a complex problem such as child care. (Joyce & Kenefick, 1997: 52)

These findings suggested that in the absence of organisationally provided training, positive learning experiences could still take place triggered more organically by staff at the local or professional group level.

#### **(b) The significance attached to training at the organisational and local level**

Studies elsewhere which have reviewed the role of training in the private sector have found that historically organisations only adopt training as one of their manpower strategies after their failure to do so has had some immediate or critical impact or where there is a general ethos of caring for and retaining staff through such initiatives<sup>29</sup>.

This point is confirmed by the experience in Irish social services, where in-service 'training' for social workers employed by Health Boards was only formally established in the period 1993-1997, following the Report of the Kilkenny Inquiry (Dept. of Health (Ire.), 1993)<sup>30</sup>. Previously, training and continuing professional development had taken place on an ad-hoc basis. Individual workers would apply for assistance to attend either long or short courses to develop their professional

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<sup>29</sup> Harrison (1988) reviewing the results of a major survey in the UK in the 1980s noted a disturbingly low level of investment in training in both public and private sectors, and suggested that: 'in the organisations where positive attitudes to human resource development did exist, they appeared to derive ... from a situation where failure to train had an immediate and critical impact, or from a more general ethos of caring for, developing and retaining staff' (pp. 2-3).

<sup>30</sup> This Inquiry, established to make recommendations for change following a high-profile child abuse case in which standards of social work practice were questioned, led to an examination of the child care services in the State and the release of funds to develop services, including those of post-professional development.

expertise and skills. Induction training and a coherent Continuing Professional Development programme were not established practices in the particular region studied.

Training officers for Health Board social workers were first appointed in 1993 (Coogan, 1998) and by 1997, had been appointed in six of the eight Health Boards in the country. The first training officer for child care and family support services in the Eastern Health Board region was appointed in mid-1997, after my fieldwork was completed. It is worth noting that the creation of this post moved the locus of control over training funds for social workers from the occupational group managers to a training officer reporting to the Programme Manager for Child Care and Family Support Services, who was responsible for organising and providing training not only for social workers but for a range of professionals. Furthermore, despite evidence emerging from the mid-1990s of staffing crises within the health board community care teams, little was being done to address it<sup>31</sup>.

The establishment of ‘training officers’ as opposed to a quality office or staff development unit is suggestive of a replication of the UK system of ‘in-service training units’ focused on organisational priorities and a functionalist approach to staff development, which may not in itself allow for the specific features and requirements of current professional practice, centred around abilities to remain flexible and creative (Parton, 2000; Fook *et al.*, 1999). Whilst individual workers were active in continuing development for some years, the health boards as organisations only began to recognise the need for continuing development in recent years following public criticism of their failure to do so in the Kilkenny Incest Case report.

At the time of this study, therefore there was no evidence of explicit organisational policies or commitment to post-qualifying development, but funds were available to social workers if they initiated a training request and if their management group supported such proposals. The allocation of resources remained in the hands of the specific occupational group, without organisational direction or control.

## CONCLUSION

The SFT course which is the focus of this study took place in Dublin in 1995 where multiple developments were challenging and changing the nature of social work practice for many participants. These contextual features can be summarised as follows:

- (a) A shifting orientation from child welfare to child protection as the dominant framework for practice within the health board social work service;

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<sup>31</sup> Fulham’s (1997) study into the ‘staff retention problems’ in one community care area in the Eastern Health Board region outlines graphically the extent of the problem in 1996 and 1997, and the absence of any coherent human resource management strategy to address it.

- (b) Increasing levels of demoralisation and anxiety among the social work group;
- (c) Unprecedented changes at organisational and policy levels within the health boards which were impinging on professional autonomy and emphasising the social control component of social work practice;
- (d) Increasing workloads and rates of referrals to health board social work services;
- (e) A destabilisation of the health board social work service, with increased mobility, problems of staff retention, an increase in the employment of non-social work professionals such as community child care workers and psychologists, and an increase in the number of newly-qualified social workers commencing work in the child protection system.
- (f) Although the course in question was funded by the health board, it was a specific event organised from within the social work occupational group. In a context where post-qualifying development was organised only through initiatives led by specific inter-professional or mono professional local groups, there was no evident organisational commitment in the innovation itself, let alone its implementation. It was a lateral, peer-led initiative.

## CHAPTER THREE: LITERATURE REVIEW: SOCIAL WORK, THEORY AND PRACTICE

### INTRODUCTION

Before embarking on the analysis of a particular initiative to change social work practices, it is necessary to establish what is 'known'<sup>32</sup> about social work as an endeavour. I will firstly consider the defining qualities of social work before debating various epistemologies of practice. Organisational, contextual and individual factors which have been found to impact on social work practices will then be identified and analysed. Particular attention will be paid to studies which have examined practitioners' use of theory, and, the cognitive and contextual processes involved both in the use of theory and in the development of professional expertise. Finally, the interface between values and theory and the politics of theory will be considered.

### THE SOCIAL CONSTRUCTION OF SOCIAL WORK

The position taken in this study is that social work is socially constructed: 'people in different social contexts create a shared reality of some set of social relations which they know as social work' (Payne, 1997: 1). Despite the efforts that are made to define the nature of social work, or to outline the ways in which it *should* be practised, sufficient studies exist to demonstrate that social work is interpreted, defined and practised in a variety of ways (Buckley, 1999; Pithouse, 1987; DHSS, 1978). These studies suggest that powerful individual, local, and cultural factors as well as socio-economic and political factors shape social work at any particular point in time and place. Research also indicates that the client's perception of the social work encounter is likely to be at variance to that of the practitioner (Maluccio, 1979; Reid & Shyne, 1969; Mayer & Timms, 1970). What the worker sets out to do and how the client experiences the intervention may be completely different<sup>33</sup>.

A social constructionist perspective (Payne, 1997) accepts the varied experiences that different actors may have and acknowledges the importance of subjective experience. Payne (1999) has analysed the different roots and types of social constructionism<sup>34</sup> and the related concept of constructivism, and concludes that social constructionism is best viewed as a *complex* of ideas.

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<sup>32</sup> Accepting that epistemologies vary in their construction of what constitutes knowledge.

<sup>33</sup> Three important studies which emerged in the 10 years from 1969 to 1979, two from the USA and one from the UK, all served to illustrate the differing perceptions that workers and clients can have of their common encounter and had an important influence on the direction of social work interventions (Reid and Shyne, 1969; Maluccio, 1979; Mayer & Timms, 1970). Other studies carried out since have served to reinforce the message that what workers set out to do, and how that is experienced are entirely different (Buckley *et al.*, 1997, Thoburn *et al.*, 1995; Dept. of Health (GB), 1995; Fisher, 1983; Rees and Wallace, 1982; Sainsbury, Nixon and Phillips, 1982;).

<sup>34</sup> Payne (1999) identifies four different sources of social constructionist as: Berger & Luckmann's sociology of knowledge (1967); American sociological work on the construction of 'social problems'

Social construction treats knowledge as outside the person, being formulated in a shared language and understanding between two people in a relationship. Constructivism treats knowledge as inside the person, being formed through perceptions, cognitions, interpretations and formulations of the world as it is presented to us in our interactions with it. (Payne, 1999: 36).

The key distinction, Payne maintains, lies not between constructionism and constructivism but between constructionism/constructivism and positivist knowledge. The latter is concerned with ‘formal scientific and intellectual knowledge’; the former with ‘everyday knowing, the perceptions of reality that form our daily behaviour and relations with each other’ (Payne, 1999: 36).

When applied to social work, social constructionist thinking

... requires the inclusion of reality and self-consciousness ... because social work activity does not merely seek to explain and account for but to interact and change the context of social constructions. (Payne, 1999: 36-7)

### **WHAT IS SOCIAL WORK?**

At this moment somewhere in the world, ‘clients’ are struggling into an office to meet with a ‘social worker’ ... In most societies this something called ‘social work’ goes on. It is widely enough spread for international associations of social workers and a shared language and literature of social work to exist. (Payne, 1997: 1)

Reviews of the social work literature, comparisons of texts from different countries, attendance at international social work conferences and contact with social workers in different parts of the world quickly dispel the notion that there is one unified type of social work or universal acceptance of the purpose and function of social work. However, I would contend that there are three features of social work which distinguish it from the myriad of other helping professions which now exist:

- (i) The dual focus on person and environment;
- (ii) The emphasis placed on the effects of disadvantage and oppression on the lives of individuals and their communities; and
- (iii) The value base of social work.

These three features do not remain uncontested nor have they remained constant over time.

*The dual focus on person and situation* has been identified as one of the most consistent themes to have emerged over time in social work (Compton & Galaway, 1994). While most definitions of social work (IFSW, 2000) acknowledge the inter-relationship between the person and their environment, the question of whether social workers should focus on individual change or environmental change remains one of the most hotly debated issues. It is relevant to this study given that the practice method in question is therapeutic in nature and predicated on an aim to enhance individual functioning. This study does not set out to establish whether one ‘type’ of social

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(Spector & Kitsuse, 1977); phenomenology and postmodernism, (McBeath & Webb, 1991); and social psychological concepts of social constructionism (McNamee & Gergen, 1992).

work is more valid than the other<sup>35</sup>, but rather assumes that there is a place in social work for different ‘types’ of intervention. While the debate on what constitutes ‘real’ social work has often been conducted in binary oppositional terms, positing individual change and environmental change at opposite ends of a continuum, empirical studies of social work suggest that workers engage in a range of activities, which are influenced by factors such as agency setting and personal style or orientation (Fook *et al.*, 2000; Harrison, 1991; DHSS, 1978;).

The current definition of social work adopted by the International Federation of Social Workers in 2000<sup>36</sup> illuminates the myriad of activities which social work encompasses. The IFSW also acknowledges the variation evident across cultures and continents:

The holistic focus of social work is universal, but the priorities of social work practice will vary from country to country and from time to time depending on cultural, historical and socio-economic conditions. (IFSW, 2000)

The respondents in this study who attended a specific short course in a particular ‘therapeutic’ method may be assumed to have seen a potential value for therapeutic approaches in their work but as their accounts will indicate, that did not necessarily translate into altered practices.

*The attention paid to structural inequalities* and the effects of discrimination and oppression gained a new momentum in social work in the last three decades with the emergence of radical and Marxist perspectives in the 1970s and anti-racist and anti-oppressive frameworks in the 1980s and 1990s (Dominelli, 1988; Thompson, 1993, 1999). Developments outside the profession, such as the introduction of the concept of human rights, and the incorporation of such rights through international declaration and conventions<sup>37</sup> are reflected in the changing curricula on social work courses<sup>38</sup> but not necessarily reflected in social work practice. The extent to which practitioners are autonomous in how they define their social work practices can vary and this may impact on the extent to which innovations filter through to changed practices with clients.

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<sup>35</sup> As the aim of this study does not extend to an examination of the effectiveness or ‘rightness’ of particular practice models, the literature review will not attempt to address studies that have carried out such an endeavour. Client studies will also not be considered, not because the client’s perspective is either taken for granted or disregarded but because the focus of this study is not an evaluation of the practice method itself but an analysis of an effort to change practices.

<sup>36</sup> ‘The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments...Social work interventions range from primarily person-focused psychosocial processes to involvement in social policy, planning and development. These include counselling, clinical social work, group work, social pedagogical work, and family treatment and therapy as well as efforts to help people obtain services and resources in the community. Interventions also include agency administration, community organisation and engaging in social and political action to impact social policy and economic development.’ (IFSW, 2000)

<sup>37</sup> The most notable in relation to human rights would be the Universal Declaration of Human Rights and the European Convention for the Protection of Human Rights and Fundamental Freedoms.

<sup>38</sup> For example on the TCD social work course, new material has been included in recent years on human rights legislation, critical perspectives on social work, and anti-oppressive practice.

*The traditional value base underpinning the practice of social work*, originating in the work of Biestek (1961)<sup>39</sup>, and finding expression in the values statements and codes of ethics<sup>40</sup> that professional associations and accrediting bodies adopt<sup>41</sup>, has been criticised and subjected to revision as the nature of social work itself has changed over time. While this Kantian framework is now only one of several identified as pertinent to the social work profession (Banks, 1995), the centrality of values to the origins and development of social work as a profession is undisputed. In the American context it has been claimed that

... one of the most critical arguments in defense of professionalism in social work practice has been that the development of independent norms, specialized helping skills, and humanitarian values enables social service work to remain autonomous, a power with the potential to offset narrow and repressive sectarian political values. (Haynes & Mickelson, 1997: 39-40)

While values differ in their emphasis from country to country (Banks, 1995), the relative ability of social workers to retain some element of independent thought and autonomy in the agency context, in the absence of powerful national or state licensing organisations, is open to question. Values Statements and definitions of social work such as those produced by professional associations may in themselves be aspirational rather than grounded. One prevalent criticism is that they tend to ignore conflicts between values and the very real dilemmas which can emerge in practice. The Irish Association of Social Workers<sup>42</sup> has produced a statement on values (IASW; 1994) which underlines this point<sup>43</sup>.

Banks (1995) in an international comparison of Codes of Ethics noted that codes differ substantially in the attention paid to potential conflict between *principles for practice* and *duties* (to the agency or to society) and that: 'codes vary in the extent to which they clearly and unequivocally

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<sup>39</sup> Biestek (1957) outlined seven principles of individualisation, purposeful expression of feeling, controlled emotional involvement, acceptance, non-judgemental attitude, client self-determination and confidentiality, which should govern the casework relationship.

<sup>40</sup> While values and ethics are terms that are often used interchangeably, a distinction can be drawn between core values which are subscribed to by members of a profession, and more detailed codes of ethics which are, particularly where a profession is self-regulating, concerned with setting standards of practice against which individual performance can be judged (see for example, NASW Code of Ethics in Reamer, 1998).

<sup>41</sup> The Irish National Social Work Qualifications Board (NSWQB) Accreditation Standards (1999) for instance specify values that social work students should commit themselves to respecting. These consist of '(i) the value and dignity of individuals; (ii) The right to respect, privacy and confidentiality; (iii) The right of individuals and families to make choices; (iv) The strengths and skills embodied in local communities; (v) The right to protection of those at risk of abuse and exploitation and violence to themselves and others' (p. 17).

<sup>42</sup> While the Irish professional association is relatively weak in the Irish context (representing about a third of social workers in the country at any one time), there was a period of protracted disagreement and debate before this draft statement was accepted.

<sup>43</sup> In the draft statement on values produced by the IASW (1994) for example: the first value asserts 'the individual's right to self-expression and independence of action' while the fourth refers to the obligation on groups in society to 'protect the human rights of all persons', begging the question: which has primacy – the individual's right to self-expression or the human rights of all persons?



state that the professional code must take priority over agency rules and procedures' (Banks, 1995: 80).

While Banks has proposed three 'types' of frameworks for moral thinking, Kantian, Utilitarian and Radical, her analysis remains rooted firmly within the UK context, emphasising the effects of 'radical social work' ideologies in the 1970s and 1980s, and the new ideologies of the 1980s and 1990s with their emphasis on consumerism and privatisation within an existing State welfare system. Values and ethics, while apparently similar cross-nationally develop in unique ways in different contexts, and there are sufficient differences between the UK and Irish contexts for caution to be required regarding the transferability of concepts and frameworks (Walsh, 1999). Parton (2000) has noted that 'While it is the role of the state which is the major influence on the way this relationship [between the individual and society] is mediated and articulated in the UK, this has not been the case in other countries' (p. 455).

In Ireland, one also has to consider the role played by religious groups on the development of social services, the impact of Catholicism as the dominant religion on the development of moral thinking, and the reluctance of the State on moral and constitutional grounds to become proactive in the defence of individual rights within a family framework. Unsurprisingly Skehill contends that the Code of Ethics of the Irish Association of Social Workers (IASW) is not only traditional in focus but also 'by its concentration on the empowering and enabling aspects of social work [makes] no acknowledgement or reference to the regulatory nature of social work' (p. 190). While she rightly concludes that the lack of acknowledgement 'represents one key power source of social workers and social work discourse: the use of language to mask or conceal' (Skehill, 1999: 190), this needs to be supplemented by an acknowledgement of the religiously-driven 'moral' nature of the many Irish voluntary social services throughout most of this century where the emphasis was on paternalistic services focused on 'rescuing' and 'making good'. Even more seismic has been the sudden shift in the 1990s towards the State becoming the biggest employers of social workers in the country and finding itself forced through public and political expectations to take a more direct (and accountable) role especially in the area of child welfare and protection. The question of which tensions and battles are fought between professionals and organisations in relation to roles and responsibilities and which professional values survive within such a time of change become significant.

*The concept of a social work ethos.* Despite contested definitions of principles and codes of ethics, one can still tentatively outline the nature of the unique social work ethos. It has been best described as:

A willingness to grapple with uncertainty, to avoid the lure of the technical fix and to consistently emphasize ... ethical and value dimensions. (Butler, 1996: 150)

Butler (1996) argues that

... the preoccupation of social work internationally with value systems, with ethical issues and with the wider policy environment *does differentiate* this profession from the more technical curative professions. (p. 154, my emphasis)

Fook *et al.* (2000) note that a broad value base

... may be shared by practitioners from other professions, but also has particular expression in specific articulated values and ethical positions within the profession of social work, such as 'client self-determination'. Professional practice in social work thus involves not just the effective application of knowledge, but also the commitment to and enactment of, particular social values. (p. 3)

Banks (1995) argues that social work is essentially a moral enterprise and that values permeate every aspect of practice: 'Most decisions in social work involve a complex interaction of ethical, philosophical, technical and legal issues which are all interconnected' (Banks, 1995: 11). No aspect of social work practice is value-free, regardless of recourse to knowledge bases, legal or technical decisions but is instead a matter of individual interpretation and priorities:

... what is a technical matter for one person (simply applying the rules) may be an ethical problem for another (a difficult decision but it is clear what decision should be made) or a dilemma for a third person (there appears to be no solution). *It depends on how each person sees the situation, how experienced they are at making moral decisions and how they prioritise their ethical principles.* (Banks, 1995: 12-13, my emphasis)

Banks and Butler agree that the essential social work ethos focuses on issues of individual rights and welfare; public welfare, and inequality and structural oppression. Challenges to social work values are seen to arise from the utilitarian principles of the bureaucratic system (Banks, 1995).

In this study, the question arises whether contextual conditions were having an impact on the possibilities and limitations in direct practice, particularly in the extent to which they challenged held social work values, such as client self-determination and respect for the individual, and whether recent changes as outlined in Chapter Two had an influence or not on individuals' adoption of the practice innovation.

#### **EPISTEMOLOGIES OF PRACTICE**

Donald Schon's work on the way in which 'minor' professionals decide what to do in action, while not specifically focused on social workers, was concerned with related (minor) professionals. From a study of how professionals approach problems or dilemmas of practice, he developed a new epistemology of professional practice (1983; 1987) which has proved to be influential in the social work field (Gould & Taylor, 1996; Gowdy, 1994) as well as in the fields of education and nursing (Palmer *et al.*, 1994).

Schon's work began from a critique of 'technical rationality' as the basis for education for the minor professions. Technical rationality suggests that positivist knowledge can be applied to real-

life problems in a deductive manner. Instead Schon proposed<sup>44</sup> an inverted relationship between theory and practice whereby significant dimensions of ‘theory’ can only be revealed through skilled practice, are implicit in action and often beyond conscious articulation. Professionals in practice face uncertain situations, ‘the indeterminate zone of practice’ and those in the minor professions, such as social work<sup>45</sup>, face additional uncertainty in the ambiguous ends and unstable institutional settings which they are located in.

From this perspective, positivist knowledge and formal theory are not neutral resources which can be drawn down and directly applied but are only of use when mediated through the complex filters of practice experience. (Gould & Taylor, 1996: 3)

Schon proposed the concept of the professional as a ‘Reflective Practitioner’: who ‘reflects-in-action’, does not depend on formal categories of established theory and technique but instead creates new and specific theories for each individual case encountered. This practitioner:

... is not limited to a deliberation about means which depend on a prior agreement about ends. He does not keep means and ends separate, but defines them interactively as he frames a problematic situation. He does not separate thinking from doing, ratiocinating his way to a decision which he must later convert to action. Because his experimenting is a kind of action, implementation is built into his inquiry. Thus, reflection-in-action can proceed, even in situations of uncertainty or uniqueness, because it is not bound by the dichotomies of Technical Rationality. (pp. 68-9)

Schon’s thesis offers an epistemology of practice which privileges tacit knowledge, and the use of intuition and creativity. It also accepts that experimentation with preconceived rules and ideas may be a necessary stage in the development of skilful practice. Instead of being ‘instrumentalists’, successfully applying theories and practice models in a methodical way, skilled practitioners are conceptualised as researchers who develop their own stock of theories through experience and reflection on experience. They build their own models and adapt them in response to the individual unique cases encountered.

Parton (2000) welcomes Schon’s work for recognising that knowledge can be derived from practice rather than applied to it and that

... social work practitioners are not so much theoretical in the sense of applying scientific knowledge as they are practical, concrete and intuitive and incorporate elements of art and craft as well as disciplined reasoning. (p. 453)

Schon has substantially influenced the ideal social work practitioner which educators now strive to develop. However, his work is not without its critics. Parton (2000) critiques it for being too generic a theory of professional expertise which fails to take into account the essential moral core

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<sup>44</sup> Schon’s conceptualisation of the ‘reflective practitioner’ was based on qualitative case studies of practitioners in a variety of fields such as engineering, town planning and clinical psychology (Schon, 1983; 1987).

<sup>45</sup> Fook *et al.* (2000) notes but does not proceed to analyse the gendered nature of the debate of relative professional status: ‘some professions (usually the women’s ones – teaching, nursing, social work) are characterised as only having reached semi-professional status, as against the more traditional men’s professions (medicine and law).’ (Fook *et al.*, 2000: 2).

of the social work enterprise. Ixer (1999) views the pursuit of 'reflective practice' as something of a 'cult' amongst educators of the professions which leaves the core concepts underexamined:

In the professions of nursing, social work and education, amongst others, reflection now features as a critical element in the enhancement of 'knowing for doing'. It claims to unlock the shackles of theory so that the learner can engage actively with praxis (theory in practice). This is called 'reflective practice'. Yet, despite the fact that the term 'reflection' is so widely used, it is equally widely misunderstood. (Ixer, 1999: 515)

Ixer cautions against the incorporation of reflective practice requirements into social work education until the conceptualisation is more refined for the social work field. Like Parton, he has concerns about the fit between the professionals upon which such a theory is based and social workers. Schon's

... own research was based on professions which were likely, in fact, to occupy the higher ground of rationality and predictability, and hence to be less challenged by the demands of rapid problem-solving than is social work. Engineers and architects, for example, are arguably less often called on to take immediate action in the context of complex decision-making. In social work, the practitioner is faced with fast changing and highly problematic information, and is required to exercise judgement under extreme pressure, knowing that the consequence of not 'getting it right' can be a child abuse inquiry or a judicial review. (Ixer, 1999: 517).

Fook *et al.* (2000) agree with the general thrust of the reflective process, namely 'that practitioners' theory is often developed inductively out of ongoing specific experiences, rather than applied deductively from generalised and formal theoretical formulations' (p. 189). They depart however from the reflective practice conceptualisation in two important ways: firstly, drawing on the work of Eraut (1994) they suggest that practitioners develop their *own* knowledge as opposed to modifying existing, handed-down formulations and hence engage in knowledge creation: '*Simply using knowledge relevantly in a particular situation involves the creation of knowledge about how to do this*' (p. 190, original emphasis). Secondly, Fook *et al.* (2000) balance the subjective focus inherent in "reflective practice" with an increased emphasis on context and power relations. They emphasise the need for reflection to have a critical component, which 'is also about uncovering assumptions about power relations, in order to make practice more egalitarian and emancipatory' (p. 212).

Eraut (1994) considers that the explication of tacit knowledge is far more complex than is allowed for in Schon's epistemology:

There are important distinctions between awareness of tacit knowledge, subjecting it to critical scrutiny and being able to articulate it in propositional form. Workers in artificial intelligence have striven to create representations of professional expertise for some fifteen years, sometimes contributing new ideas but also revealing how much professional knowledge is not amenable to capture for representation in current computerized forms ... One of its best established findings is that people *do not know what they know*. (Eraut, 1994: 15, original emphasis)

Maintaining that Schon was 'principally concerned with developing an epistemology of professional creativity rather than a complete epistemology of everyday professional practice' (p.

143), Eraut identifies a number of weaknesses in the structure of Schon's theory: it relies too heavily on specific examples (critical cases or incidents) which emphasise creativity and the use of intuition; fails to clarify what is entailed in the reflection process; and does not address the dimension of time and its impact on reflection (between reflection in 'cold' situations where there is time to pause and reflect and in 'hot' situations where reflection is rapid and constrained by the need to continue in action). Eraut argues that the concept of reflection-in-action is problematic and that Schon

... does not have a simple coherent view of reflection but a set of overlapping attributes [from which] he selects whichever subset of attributes best suits the situation under discussion. There is insufficient discrimination between the rather different forms of reflection depicted in his many examples; and this overgeneralization causes confusion and weakens his theoretical interpretations ... it would still benefit from careful consideration of how patterns of reflection vary according to profession, situation and circumstance. (p. 145)

He concludes that:

... to rescue Schon's original contribution from this morass, I believe it is necessary to take the term 'reflection' out of his theory, because it has caused nothing but confusion. I find it more helpful to view all of Schon's work on professional knowledge, including his earlier work with Argyris, as a theory of metacognition ... Schon's notion of rapid reflection-in-action provides an original and useful theory of metacognition during skilled behaviour. His ideas about reframing and reflective conversations with the situation might also be construed as contributing to a theory of metacognition during deliberative processes. This makes a clear distinction between deliberation and reflective metacognition of that deliberation. (p. 149)

Eraut (1994) also makes a point of significance to social work when he notes that for many professionals, 'work' can contain mainly

... routine cases or well-defined problems that can be handled without a great deal of deliberation unless something unexpected occurs. Schon described this in terms of proceeding normally until some cue triggers reflection-in-action. What Schon did not discuss was the extent to which cues are liable to be missed or disregarded by a practitioner under pressure. (p. 152)

Schon's work as a theory of applicability to social work is, I conclude, flawed in ignoring the combination of, and distinction between, well-defined and ill-defined problems which practitioners deal with and in being unable to accommodate 'failures' or 'mistakes' in professional judgement and action which may come about not through any fault in the 'reflection-in-action' process but through the presence of other factors. In the social work field, other factors exist – such as inexperienced workers handling overly complex cases; gaps in supervision and surveillance; political and societal expectations; the impact of the nature of the work itself and the anxiety generated in highly-stressful cases; and the extent to which social work is a moral enterprise. Nonetheless, Schon has made a contribution to social work in developing a theory which places artistry and individual abilities back at the heart of social work practice and one which locates the practitioner as a developer of practice theory, as well as an interpreter of formal theory.

## TYPOLOGIES AND 'ORIENTATIONS'

That the nature of social work is both ambiguous and debated is explicitly accepted by those who have made efforts to identify particular 'types' of social work (Payne, 1996; 1997; Howe, 1987).

Payne describes three different views of social work held by those within and outside the profession:

- a) reflexive-therapeutic views;
- b) socialist-collectivist views; and
- c) Individualist-reformist views (Payne, 1997).

Howe (1987) outlines four different orientations to practice based on two dichotomies of social regulation/social change, and subject / object gaze. These result in four distinct types of social work: functionalist; interpretivist; radical humanist and radical structuralist.

Both typologies make distinctions based on the extent to which social work is a practice of enabling clients to adapt to their environment (Howe's functionalist and interpretivist paradigms; Payne's reflexive-therapeutic and individualist-conformist views) or a practice which accepts the primacy of environmental and structural change over individual adaptation (Howe's radical humanist and radical structuralist paradigms; Payne's socialist-collectivist view). Both theorists conclude that a form of social work which is functionalist in nature, which assumes a consensus view of society and which aims to help people through diverse therapeutic processes of change and growth, is the most common form in modern Westernised societies, a view that is shared by Skehill in her analysis of the nature of Irish social work (1999). Fook *et al.*, however, argue that the presentation of orientations as either/or alternatives is a result of 'binary oppositional thinking' and is fundamentally flawed as it does not reflect the juggling of paradigms which empirical research suggests is an everyday experience for the experienced practitioner (Fook *et al.*, 2000).

Empirical studies support the view that individual workers differ in their orientations to practice. Crousaz (1981) found that 'social workers provide a complex mixture of practical and supportive help according to the kind of problems presented *and inclination of the worker*' (Crousaz, 1981: 52, my emphasis). Stevenson and Parsloe note that:

Statutory duties, agency priorities, departmental policies and resource levels create the scene within which caseload management decisions are taken. *In addition*, clients who are vocal and persistent in their demands, *and the social worker's individual style also play an important part in such decisions*. (DHSS, 1978: 77, my emphasis)

Fook *et al.* (2000) found in their longitudinal study that

... most social workers do not adhere faithfully to one theoretical paradigm. The consistency in their work is more likely to relate to an affinity with certain values or ideology, or, in the situations of those in more narrowly defined positions this may be reflected in certain programmed roles. Procedural knowledge, in this sense, takes the form of workers formulating their own practice theory on the basis of an amalgam of different knowledges. (p. 143)

A distinction clearly needs to be drawn between typologies and orientations.

Typologies may mask as much as they reveal. They may be useful in identifying broad trends in forms that social work *can* take, and in analyses of the location of social work in regard to social control and regulation. There are however dangers inherent in uncritical adoption or application of typologies as ‘master-statuses’ (Becker, 1967) which can fully describe the nature of social work practice at any specific point in place and time<sup>46</sup>.

Another danger is that typologies may be used as a form of short-hand stereotyping, which creates ‘labels’ and expectations for practitioners and influences the expectations of clients, other professionals, managers and agencies. Typologies may not allow for multi-dimensional and flexible practice if the ‘types’ are assumed to be fixed categories. However, if positions are understood as flexible and contestable, as potentially short-term as theory itself is, and consisting of *orientations towards* practice, then they can be useful in exploring where different workers’ sympathies lie, why practitioners make particular decisions, or how they theorise their practice.

Orientations can change, as workers interreact with agency and client and with social, economic, political, cultural and personal influences in the wider world. As the previous chapter illustrates, the requirements or expectations placed on social workers by the public, politicians, legislators, policy-makers, employers and managers can change over time and have profound implications for the practice of social work even whilst not dictating the shape of practice. Tensions can exist and develop between what is expected of social workers from an agency or organisational perspective and their own perceptions of their role as professionals with a specific occupational ethos.

Studies which have explored the cognitive processes of social workers in practice also suggest that orientations can overlap. Thus while a worker may subscribe generally to an orientation they may also adopt a different orientation if it makes better sense of a specific situation, or at a certain stage of expertise be competent in ‘juggling paradigms’ (Harrison, 1991).

Typologies therefore are of limited use if they imply a particular pattern of perception, cognition and action by a practitioner in a linear positivist manner<sup>47</sup>, and if allowance is not made for the

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<sup>46</sup> As Skehill’s analysis concedes, modern society is ever-changing, ‘certainties are being replaced by uncertainty, contradictions and doubt. Clearly social work is being affected and is changing within this context’ (1999: 197).

<sup>47</sup> Sociological analyses of professional groups have identified a distinction between ‘major’ professions such as medicine and law, focused on what are seen to be unambiguous ends such as health or success in litigation, located in stable institutional contexts and premised on a positivist or ‘technical rational’ epistemology of practice, and ‘minor’ professions such as social work which are susceptible to shifting, ambiguous ends and unstable institutional contexts of practice. These analyses have paved the way for alternative explanations of practice in such minor professions as social work as it is argued that efforts to

socially constructed nature of social work and for the varied forces that can influence the shape of social work practice<sup>48</sup>.

The concept of paradigms allows for theories and models to be considered fluid and dynamic, with theorists such as Howe accepting the possibility that paradigms themselves can shift and that over time new paradigms can emerge which will also shift the meaning and position of different theories within each paradigm (Kuhn, 1974). One such shift which has occurred since Howe (1987) has been the increasing influence of constructionist/constructivist ideas and the emergence of social constructionist models for practice (Parton & O'Byrne, 2000). This is not, in itself, however a sufficient paradigm shift to challenge the typology of social work theories expounded by Howe. The original framework for analysing social work theories (Whittington & Holland, 1985) drawn on by Howe places greater emphasis on social constructionism and related concepts such as labelling theory within the interactionist paradigm (renamed interpretivist by Howe). Social constructionist practice theories such as SFT and Narrative Therapy (White & Epston, 1991) however are located within the sociology of regulation rather than radical change unless practitioners adopt them as a conscious strategy with which to raise consciousness as a step towards a more structurally challenging form of practice.

#### **ORGANISATIONAL FACTORS AFFECTING THE SHAPE OF SOCIAL WORK PRACTICE**

A range of studies have examined organisational factors which can impact on the shape of social work practice.

##### **'Direct' and 'indirect' work**

Direct client contact has been found to be only one part of the social work task.<sup>49</sup> Time is also spent on indirect work: obtaining resources; negotiating with other agencies on behalf of a client; record and letter writing, telephoning and liaising with colleagues. These fall into the category of 'desk work' (Crousaz, 1981). Another major time consuming activity is travel – either with clients or

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understand how minor professionals practise will fail if based on a 'technical rational' epistemology of practice (Schon, 1983: 23).

<sup>48</sup> Stevenson's study (1978) in particular gives some weight to Payne's concept of general orientations but also suggests that although the work engaged in may consist of similar or identical ingredients, the focus or emphasis can vary irrespective of the agency mandate. Although Stevenson concludes that: 'a feature of all the studies was the wide ranging freedom social workers had to choose the style and content of their direct work with clients' (p. 135), her study was carried out in the UK in the mid-1970s before the evolution of the child protection system and therefore it cannot be assumed that the practitioners studied in this fieldwork enjoyed the same level of professional autonomy.

<sup>49</sup> In one review of research studies into social work in the UK, client contact accounted for less than one third of social work time in all studies and as low as 17% in some (Crousaz, 1981). The figure of one third is still taken to be an approximate figure for client contact (Payne, 1997).



alone<sup>50</sup>. Other activities include supervision and consultation, conferences, meetings, teaching and learning. Crousaz (1981) concludes that

In practice, client contact might be a relatively small part of the total time spent by a social worker on a particular case, according to the type of case. Overall, this accounts for less than a third of social workers' time in all studies and as low as 17% in some. (p. 49)

Social workers can also have specific 'indirect' positive effects on clients through their contact with other professionals<sup>51</sup>. Workers may spend time researching, writing reports and making applications for changes in services, new service initiatives, or funding requests which benefit clients but do not count as 'direct' work. In one large study (DHSS, 1978) most social work respondents accepted that a considerable amount of indirect work on behalf of clients was a central and essential part of their role.

This raises the question: if social workers spend on average only one third of their time in direct client contact<sup>52</sup>, and if clients rate the provision of practical supports and help as highly as more sophisticated therapeutic work (Mayer & Timms, 1970), how relevant, and in what circumstances, will any theory of change be, which focuses primarily on individual cognitive and behavioural processes and remains unengaged with the wider social, economic and structural processes which impact on clients' lives?

### **The role of the team leader**

In the larger services such as hospitals, health boards and probation offices, practitioners are organised into teams, supervised and managed by a team leader, who is accountable to senior managers within the organisation. The team leader is a figure of pivotal importance, a perception borne out by research studies (DHSS, 1978; Crousaz, 1981).

While social workers often have considerable autonomy in deciding how to handle individual cases once allocated, the team leader generally decides what will be allocated and to whom. In this way,

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<sup>50</sup> In recalling one piece of work which involved long car journeys, Stevenson described her work as 'essentially practical. The car was cold and often smelly. There was no deep conversation, let alone fancy therapeutic talk of which ... we were sometimes accused. There was however, an underlying belief that this course of action offered the best chance for Ethel ... it was underpinned by an absolute belief that the job was worth doing' (Stevenson, 1998: 154). The point is clearly made that good social work does not need to mean engaging formally in therapeutic sessions, nor does talking itself necessarily provide what is needed – practical support, belief on the part of the practitioner and acceptance of the client's view are what she indicates makes the difference in her work with Ethel.

<sup>51</sup> In a study of social work in a primary health care setting, it was reported that:  
the doctors working ... claimed that the presence of social workers had increased their awareness of social problems generally, and in relation to specific patients, the increased knowledge and fuller understanding of the social situation derived from the social workers and allowed them to provide more comprehensive care (Williams & Clare, 1979).

<sup>52</sup> Presuming that Irish social workers at the time under study were moving towards a form of bureaucratised practice, similar to that in existence in the UK when the research studies quoted were conducted.

the team leader has a considerable impact on the kind of work undertaken and the way in which it is carried out. The team leader also has a continuous, potentially conflicting responsibility to ensure the effective management of individual cases and promote the professional competence and development of the individual worker. Through the supervisory relationship, the team leader may be influential in promoting new ways of working, or in resisting innovation. Managers in social work services are, like social workers, not necessarily a homogenous group:

Supervisors, like workers, differ, and some may be more interested in their job security and tenure than in the client's needs for service or the worker's need for both support and learning opportunities. (Compton & Galaway, 1994: 203)

While it is hard to argue with the assessment that 'it is difficult to exaggerate the influence of the team leader on the team' (DHSS, 1978: 310), this needs to be tempered with the acknowledgement that team leaders are relatively recent in the Irish community care social work structure. Prior to 1990, one senior social workers supervised all the social care professionals in one health board area. Team leaders were first appointed in 1990 and throughout the 1990s remained responsible for large teams of social workers (approximately 1:10/15) and a widening range of responsibilities. At the time of this study, the establishment of team leader posts was still relatively recent. Previously social workers were relatively under-managed, and as a consequence more autonomous in defining and controlling their work.

### **Agency function**

Social work services are provided by a range of agencies and evidence suggests that agency function has a significant effect in shaping the social work service that is offered. Agencies such as the Probation and Welfare Service and the Health Boards offer what are sometimes called statutory social work services, where a particular regulatory mandate exists<sup>53</sup> and services are seen to be qualitatively different in orientation and practices because they deal with 'involuntary clients'.

Clients ... can be described as involuntary [where] they have not chosen to receive the services they are being given. In fact these clients might be actively opposed to receiving the service. They might believe that it is unnecessary and intrusive. The clients receive the service offered either because of a court order or the threat of some other legal sanction. (Trotter, 1999: 2)

The distinction between voluntary and involuntary clients is not always clear-cut and can change over time, but the agency function in statutory settings is perceived by workers, other agencies and clients as at the social regulation end of the continuum of social work services.

Agency function in medical settings similarly affects the shape of the service offered. Part of the social work function in medical settings is increasingly to contribute to efficient management of

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<sup>53</sup> In the case of the former, probation officers are required by law to complete social enquiry reports on selected offenders and to provide services to those offenders placed on probation orders; in the case of the latter, social workers are required by law (as health board employees) to investigate concerns of child abuse and neglect and to take action to protect children in situations where that is deemed necessary.

health resources by assisting the speed of discharge, and freeing up beds (“discharge planning”). Such requirements tip the worker’s role in the direction of the ‘common good’ and away from championing individual rights and the advocacy role that social workers traditionally occupied. Social workers in voluntary agencies in Ireland generally have a high degree of autonomy in their work and more flexibility in how they define their role.

Workers in adult psychiatry and child psychiatry settings function as part of a multi-disciplinary team and engage in therapeutic work with individuals and families. Given the hierarchical nature of medical structures and the location of the social worker within a team headed by a medical consultant, one might expect that the social worker’s role would be influenced by the consultant’s orientation but this may also vary according to individual styles of management.

Depending on the agency mandate, organisational structure and mono or multi-disciplinary context therefore, social workers may be prone to powerful expectations as to how their role should and can be interpreted.

### **Socio-political influences**

Agencies exist within a political and social context, which affects how the workers within them operate, and how they deal with clients. That agencies and subsequently individual practitioners are profoundly affected by the broader political and social context has already been established in Chapter One which outlined changes to the shape of community care social work in Ireland through the evolution of the ‘child protection system’. Another example of how socio-political expectations can influence agency priorities is the case of Probation in the UK in the 1990s (Ward, 1996) where a similar combination of changing public and political expectations altered the thrust of service delivery. In the case of Probation in the UK, ‘Government policy was directed towards changing the culture of the Probation Service to fit in with a penal policy ‘to condemn a little more; to understand a little less’ (Ward, 1996: 125). Probation’s link with social work education was severed in 1995. In 1998, Government policymakers proposed a reorganisation along the lines of the American ‘correctional department’ model – concerned more with monitoring offenders on community sentences and less with advising, assisting and befriending offenders.

In both these cases, changes were implemented which fundamentally altered the nature of services delivered to client populations. But an assumption that these changes were unilaterally imposed on social workers may be simplistic. There is some evidence in the Irish context that particular individuals and professional bodies actively contributed to the focus on child abuse in order to increase resources for such problems but also to claim ‘child protection’ as a legitimate activity for social workers to control. In the UK, sociologists have critiqued such developments and challenged the assumption that social workers were, and are, powerless in the definition of their trade:

Professionals' ideological defence of established social work is a form of defence that involves a self-portrayal of social work actors as individually and collectively reactive, hapless and powerless 'agents' of governments or of mysterious structural 'forces' of one kind or another. This defence is conveniently breached for some professional purposes. A case in point is professional actors' energetic role in the expansion of 'statutory' social work in the 1980s. For example, in their social construction of 'child abuse', particularly sexual abuse, professional social work actors have been *proactive* to the point of evangelical fervour in proclaiming, largely on the basis of anecdotal or in some other way unreliable evidence, that a massive hidden problem exists and in opportunistically shaping child care policies in ways that involve the expansion of professional social work. (Sibeon, 1991: 160)

Social and political developments may be influenced by professional interest groups and dominant individual 'experts'. Social workers in these ways also affect what they are mandated by society to do<sup>54</sup>.

### **The agency as a bureaucracy**

In the American context, social work 'began, grew and developed to its present stage as a professional practice within a bureaucratic structure' (Compton & Galaway, 1994: 193).

Irish social work in community care settings at the time of this study and subsequently had become a professional practice operating within a bureaucratic structure, located close to State power and influence. Workers in voluntary organisations and other settings did not experience the same constraints.

The positioning of the individual practitioner within a bureaucratic structure has implications for the ways in which social work is constructed, delivered and experienced by the client: firstly because levels and areas of autonomy controlled by the practitioner change; secondly because certain types of practices and problems are prioritised. Wassermann argues that:

The professional social worker in a public welfare bureaucracy serves two masters – his professional self including intellectual and moral criteria and his employing organisation and its demands and constraints. (Wassermann, 1979: 206)

Whether the 'professional self' can endure in a bureaucratic organisation is questioned by Rhodes, who proposes that individual moral responsibility derived from the value base of social work, is compromised by the specialisation, rules, hierarchy and procedures that epitomise a bureaucratic structure:

In these 'people-changing' and 'people-processing' organizations, individual social workers often seem caught up by organizational forces well beyond their control. Their work may be determined more by institutional rules than by clients needs, and they often find themselves mired in routinized procedures defining a narrow range of client

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<sup>54</sup> As well as doing so through choices and priorities set in organisational contexts. Howe (1986) found in the early 1980s in the UK, most qualified and experienced workers were concentrated in work with children and families which was seen to be 'more complex, difficult and important work than work with other client groups' (p. 25).

problems. Instead of providing 'care' and empowerment, they become a force for social control or for ineffective palliative measures. (Rhodes, 1986: 133).

Sibeon (1991) asserts that professional allegiance in bureau-professional systems changes from a focus on the needs of clients, to a more self-serving professional and bureaucratic defence. Rhodes (1986), and Compton and Galaway (1994) accept the disadvantages of the bureaucratic structure, but do not accept the agency as a 'given', and instead exhort practitioners to organise themselves and their clients, to challenge the organisation of services and to continue to seek the ideal of professional practice

... by applying principles and methods to resolve problems determined by unique client input and professional judgment rather than by employing standardized procedures toward some predetermined goal established by a hierarchical authority. (Compton & Galaway, 1994: 198)

Whether in practice, when faced with a complex mixture of pressures including heavy workload, statutory responsibilities, accountability to team leader and agency, workers can operate in this ideal way is debatable. To work in a reflexive way with clients requires time, opportunity to reflect, belief in clients' ability to make changes, and skills to help bring about change, and above all support in doing so. Research indicates that workload pressure is an obvious deterrent to experimentation (DHSS, 1978). The amount of supervision that even very inexperienced social workers receive in Irish services has been found wanting (Loughran & Walsh, 1998). In these circumstances, one needs to be realistic about what is expected of practitioners in the tense relationship between 'ideal' professional standards and 'real' agency requirements.

Howe's (1986) study illuminates the practice of social workers in welfare bureaucracies:

Organisationally, the critical areas of practice in field social work are those which have implications for both the department's resources and its statutory *raison d'être* ... key areas of practice were controlled by managers as they interpreted and operationalised the political and legal remits of the personal social services. Although *the manner of practice was open to interpretation by fieldworkers, control over the content of practice lay outside the purview of practitioners* and rested with managers. (Howe, 1986: 94, my emphasis)

Yet Howe asserts that although for years, 'the organisation has been blamed for the difficulties experienced by professional social workers' (p. 159), alternative forms of management and accountability may pose as many new problems as they address old ones. He concludes that

... social workers have little choice but to accept the defining boundaries of their practice. It is no good jeering from the sidelines. As an occupational group, social workers have to join in; they have to explore and understand the nature of their work from within its current confines ... These prescriptions demand patience as well as a willingness to renounce the narcissistic and immodest proclivities implied in many of social work's theoretical interests. (pp. 163-4)

While calling for pragmatism on the part of the professional group, Howe (1992) also critiqued later developments of the child protection system, particularly how 'During the translation of the problem of child abuse into a set of judicial and bureaucratic procedures, therapeutically oriented professional practices found themselves out-manoeuvred' (Howe, 1992: 491).

While the developments outlined in Chapter One suggest that Irish community care social work was in the process of being re-defined into a 'child protection system' in the mid-1990s, it is unclear whether 'therapeutically-oriented professional practices' have either remained in place or been similarly subordinated.

## **INDIVIDUAL FACTORS AFFECTING THE SHAPE OF SOCIAL WORK PRACTICE**

### **Individual interpretations**

The most significant of the large-scale studies of social work activity, (and the most comparable to the social work field in this study) examined social services in 39 area and hospital (general and psychiatric) teams in the UK (DHSS, 1978). Several useful findings about the content and shape of social work practice were made:

- (a) the diversity of problems and client needs made it difficult for social workers to generalise about their methods of work. While most workers referred to their work as 'casework', 'the number of meanings ascribed to this rendered it less than useful in clarifying what social workers actually did with clients' (p. 103), and for most it embodied a number of activities used singly or in varying combinations.

The generic casework approach was one which not only recognised multiple causation of problems but, in turn, drew from a number of specific techniques of intervention and cast the social worker in a number of different roles. (p. 103)

- (b) the extent to which social workers planned their interventions varied: at times activities constituted part of a carefully worked out plan, but at other times, interventions were chosen on an ad hoc basis in response to unfolding events (akin to Eraut's 'cold' and 'hot' situations).
- (c) while most workers seemed eclectic in their methods and focused on the psychological, social and material causes of problems, there were some important differences in *emphasis*. For example, a few workers in one local authority office focused mainly on 'in-depth' work, concentrating on the emotional functioning of clients and seeking to offer help by use of the social worker-client relationship, or by adopting an interpretative role. Others concentrated on practical 'service provision'. And there were indications of tensions between the two. 'In-depth' work was often the subject of derogatory remarks in the local authority setting: 'too much concerned with changing the personal behaviour of clients, too little concerned with changing the environment', but those who adopted an 'in-depth' focus were adamant that it did not diminish their interest in environmental problems or their sensitivity to material needs. In other social work locations, such an approach was accorded high status and equated with 'real' casework.
- (d) Particular approaches to practice were equated to specific settings and agencies. The most common remarks about 'in-depth' work centred on its inappropriateness in a local authority

setting. Some found that they could use this skill only in a limited way on a small number of cases because of other demands on their time. Other workers, in psychiatric hospitals, engaged more extensively in psychotherapy or 'psychotherapeutic discussion'. In the settings surveyed, with the exception of designated community work posts, most practitioners were engaged in work which reflected a therapeutic-reflexive or individualist-reformist orientation (Payne, 1997). While virtually all workers saw practical assistance of clients as part of the social work task, in some cases, social workers' *own orientations* shaped their work towards practical provision. The finding that social workers do not necessarily engage in change-work is also supported by studies of social work in various settings which found that in many cases studied, no particular change was sought (Goldberg *et al.*, 1976, 1977, 1978). Work often consisted of supporting or monitoring rather than actual attempts to achieve change.

A second study of relevance carried out by Sinclair and Walker (1985) was an evaluation of task-centred casework in two London intake teams.<sup>55</sup> In only 35% of cases was the task-centred model completed and in only 17% of all cases did clients feel that 'substantial inroads' had been made into their problems. Client characteristics which appeared to influence outcome included motivation, capacity and opportunity. A key element was agreement between client and worker regarding the problem and what was to be done about it: 'A simple agreement scale was constructed and, with one exception, all the high scorers on this scale also reported that their problems were completely or substantially reduced' (p. 77)<sup>56</sup>.

However the most significant finding for this study was *the influence of individual workers on outcome*:

Some workers got a relatively high percentage of their clients into task-centred work, and these clients were likely to report considerable problem reduction. Other workers had a relatively high proportion of drop-outs, and those clients who did not drop out were less likely to be satisfied with the results. As a result of these two processes, the 'successes' were almost completely concentrated in the caseloads of four of the thirteen workers. By contrast, the 'worst' five workers had only one success case out of forty. (p. 79)

The authors conclude that

In developing task-centred work it is necessary to take account of possible differences between individual workers ... Curiously, investigation of individual differences in the effectiveness of social workers appears to have been neglected despite the crucial relevance of this subject to social work training. The present study suggests that there probably are such differences and that they are important. (p. 82)

Other studies have identified worker competencies rated highly by clients and/or social workers (Drake, 1994) or examined components of the 'helping alliance' between workers and clients (Dore

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<sup>55</sup> Social workers received training in task-centred casework and were then required to carry two cases each using the approach. Forms were devised to describe the work, using a simple 'before and after' design, and clients were interviewed by an independent assessor following closure of the case.

<sup>56</sup> This supports the work of Maluccio cited earlier, which found that agreement between worker and client was a crucial component of 'successful' work.

& Alexander, 1996) but the issue of whether workers are intrinsically more suited to certain approaches over others has remained unexamined and will be considered in this study.

### **The use of theory by practitioners**

‘Theory’ as a concept has many different meanings and a distinction needs to be drawn between ‘theory’ and ‘knowledge’. Theory is only one form of knowledge that professionals draw on. Drury-Hudson (1999) distinguishes between theoretical knowledge<sup>57</sup>, empirical knowledge<sup>58</sup>, procedural knowledge<sup>59</sup>, practice knowledge<sup>60</sup> and personal knowledge<sup>61</sup>. Fook (2000) considers that ‘theory’

... can vary from a single descriptive idea, concept or label, to more complex sets of related ideas. Often just ‘naming’ or labelling a piece of behaviour can function to provide some explanation, or connect the behaviour with related ideas. (p. 4)

Payne (1997) makes a distinction between theory as ‘a general statement about the real world whose essential truth can be supported by evidence obtained through scientific method’ (p. 35), and a social constructionist/postmodern view of theory which has three different possibilities:

- a) *Models* ‘which describe what happens during practice in a general way, applying to a wide range of situations, in a structured form, so that they extract certain principles and patterns of activity which give the practice consistency ...
- b) *Perspectives* on a complex human activity [which] express values or views of the world which allow participants to order their minds sufficiently to be able to manage themselves while participating ... [and]
- c) Explanatory ‘*theory*’ [which] accounts for why an action results in particular consequences and the circumstances in which it does so’ (p. 35).

Payne argues that social work theory should be considered in the second looser postmodern sense, because ‘most social workers use ‘theory’ to mean ideas that influence them as opposed to things they do in practice’ (p. 37).

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<sup>57</sup> Defined as ‘a set of concepts, schemes or frames of reference that present an organised view of a phenomenon and enable the profession to explain, describe, predict, or control the world around him/her’ (p. 150)

<sup>58</sup> ‘Knowledge derived from research, involving the systematic gathering and interpretation of data in order to document and describe experiences, explain events, predict future states, or evaluate outcomes’ (p. 150)

<sup>59</sup> ‘Knowledge about the organisational, legislative, and policy context within which social work operates’ (p. 150)

<sup>60</sup> ‘Knowledge gained from the conduct of social work practice which is formed through the process of working with a number of cases involving the same problem, or gained through work with different problems which possess dimensions of understanding that are transferable to the problem at hand’ (p. 150).

<sup>61</sup> ‘An inherent or spontaneous process where the social worker is necessarily committing him or herself to action outside of immediate consciousness, or involves action based on a personalised notion of common sense. Such knowledge includes intuition, cultural knowledge and common sense’ (p. 150).



Empirical studies confirm the perception that practitioners in general do not rely on the use of theory or particular practice models in a *linear, methodical manner* to guide their practice (DHSS, 1978; Carew, 1979; Corby, 1982). For the purpose of this study, theory will be considered as a broad-ranging concept, encompassing single ideas and concepts which may be neither generalisable nor explanatory, as well as more complex interrelated structures.

Fook *et al.* (2000) make an important distinction between knowledge and skills, maintaining that for skilled social work practice both *substantive* information (or theory) and *procedural* knowledge (or skilled knowledge of how to use that information, especially in unpredictable situations) are necessary:

When professionals learn to practise, they must develop knowledge *about* a phenomenon, and knowledge about *how to* use that knowledge ... the former may be termed 'knowledge' and the latter 'skills'. (Fook *et al.*, 2000: 9, my emphasis)

'Formal' theory is defined (Fook *et al.*, 2000) as that which has been taught on academic courses, including practice methods. In this study, I will use the term 'formal theory' in the same way but will distinguish between an ethos or philosophy of practice (equivalent to Payne's perspective) and a practice method (equivalent to Payne's model).

Several features of practitioners' use of theory were identified in the DHSS (1978) study.

### **Deviations from textbook models**

Detailed questioning of the workers indicated that the specific approaches to practice (equatable to the 'model' level) most commonly mentioned were rarely understood and practised in the ways specified in textbook models. For example, crisis intervention theory was rarely used as a step-by-step approach to promote the client's problem-solving capabilities, but was:

... frequently used to describe a crisis for the worker or agency ... (with social workers') offers of practical support and intervention ... geared towards allaying their own anxiety, especially in 'at risk' cases, rather than the planned first step of a crisis intervention model. (pp. 115-6)

The study also found that the core principles of 'contract work', involving the client in discussions about role and time limits, were not adhered to; what was described as contract work was workers drawing up plans by themselves. Similarly in task-centred casework, descriptions of practice did not accord with the prescribed method, but instead 'was interpreted rather widely to mean purposeful or focused work' (p. 121).

The DHSS study found that workers did not modify definitions of task-centred work because they had experienced difficulty in implementing the textbook model, but because 'they never fully

explored the relevance of the text book model' (p. 121). The reason for this is not explored, but two possibilities can be suggested:

- (i) practitioners had not spent enough time on training courses or placements exploring the nature and relevance of different approaches; or
- (ii) agencies did not support an theory-based approach.

Both possibilities have received some support from subsequent studies. Marsh and Triesolitis's (1996) survey of recent social work graduates found a high level of dissatisfaction with the teaching of social work methods on their training courses. They also found that, while most respondents saw value in a good theoretical grounding, they were not encouraged to apply theory in their daily practice<sup>62</sup>.

This accords with Stevenson's and Parsloe's (DHSS, 1978) point about the role of the team leader/supervisor in shaping practice, and also relates to Pithouse's (1987) observation that, in area social work team culture, workers saw themselves as the definers of good practice. A point of some interest but not expanded in these studies, is why in some settings, peers become the definers, whereas in others, the team leader becomes the definer.

### **Matching client/problem and approach**

Workers repeatedly referred to the problem of matching client and problem to approach at the assessment stage. A study of social assessments in a specialist (probation) setting, however, found that both practice models and theories were used formulating assessments and most workers used a psychosocial framework (Curnock & Hardiker, 1979). Secker found that social work students who used a 'recipe' approach and tried to apply particular methods methodically from the outset frequently ran into problems, because clients resisted this approach to practice especially from social work students who focused more on the right steps to take than on the establishment of a helpful relationship (Secker, 1993).

### **Personal models for practice**

Some experienced workers indicated that they had built their own models for practice in an eclectic fashion. Curnock and Hardiker had also concluded that social workers would never rely exclusively on theoretical knowledge as they 'ultimately must rely on a particular blend of feelings, observations and ideas in order to come to an assessment' (Curnock & Hardiker, 1979: 170). The building of personal models is also supported in a study of 'expert' practitioners by Harrison (1991) and in Fook *et al.*'s (2000) more recent work on the development of professional expertise.

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<sup>62</sup> Almost six out of ten of their respondents reported that their supervisors hardly ever or never encouraged them to apply theoretical approaches and explanations to their daily work (Triesolitis & Marsh, 1996).

## Implications of these studies

Although these 'first generation' studies have been criticised for approaching the research of practitioners' use of theory with an *a priori* assumption that

... to use theory properly social workers must be able to clearly articulate their knowledge in the form of propositions recognisably derived from the relevant literature. (Secker, 1993: 10)

and for ignoring the cognitive processes practitioners used, an exception can be made in the case of the DHSS study, an empirical, inductive study which examined in detail the practices of social workers, and which was social constructionist in its orientation. Several of the hypotheses formulated by the 1978 DHSS study deserve to be considered:

- (i) That the range of activities which workers engage in, from those requiring no theoretical framework to those requiring skilled application of professional knowledge, militates against the maintenance of any theoretical framework.

The constant switching between such different levels may have diluted any attempt to consolidate practice or to conceptualise in certain areas ... The difficulty experienced by our social workers in describing their approaches is, perhaps, understandable, given the enormous range of problems they encounter and the paucity of categories in which to classify different problem situations and the tasks involved in the social work process. (DHSS, 1978: 136)

- (ii) That practice theories are of most value when offering practitioners *ideas* that they use to create their own practice theories and that the greatest contribution of different approaches may lie in selective use of their components;
- (iii) That workers cannot articulate a theoretical foundation to their work because they have internalised theory that they use in practice. They are neither conscious of it or able to talk about it, and more experienced workers operate on an intuitive level, responding to the immediate situation without conscious reliance on any theoretical framework.

Some support for each of these possibilities has been found in subsequent studies. In relation to the first point, Marsh and Triesolitis (1996) in their large-scale survey of social work and probation graduates, suggest that respondents drew on a range of theories because 'no single perspective could respond to the varied needs of the users of services' (p. 54).

Marsh and Triesolitis identified over 80 different theorists and theoretical approaches taught on courses but concluded that: 'the explicit and frequent use of theory in practice is something that for a significant percentage of the newly qualified workers stops with the end of their course' (p. 64). This study did not, however, distinguish between theorists, theoretical approaches and models, and relied on self-report by respondents in naming their theoretical influences without establishing through case examples or scenarios *how* these were being used or examining whether they were using selective concepts from formal theory.

Fook *et al.* (2000) interrogated more closely graduates' use of theory through case scenarios and examples from practice. They found that, while social workers were relatively atheoretical in their first year of practice, in subsequent years workers demonstrated an increasing ability to consider problems from a range of perspectives and drew from a variety of sources, the knowledge base(s) from which they constructed solutions. Nonetheless their use of formal theory did not equate with textbook versions. For both newly qualified workers and more experienced workers, 'the use of theory they actually articulated was confined to particular concepts, terms, assumptions rather than a complete adoption of particular formal theories, frameworks or models' (p. 74).

More importantly,

'despite the professed adherence of many of the workers to particular theories at the end of their first year in practice, there was little evidence of the complete adoption of particular formal theories either in their responses to vignettes or their descriptions of critical incidents' (p. 103).

In relation to the second point regarding the selective use of aspects of theory, Secker summarises a range of views which confirm, that practitioners use some theory but as a 'framework', which is either assimilated or integrated into practice, and that 'different theories or aspects of them which seemed relevant to a particular situation are 'amalgated' and used as seems appropriate' (Secker, 1993: 11).

In relation to the third point, the concept of intuition has been placed centre-stage by Schon's work (1983; 1987). Fook *et al.* (2000), in considering the extent to which knowledge is internalised and implicit, suggest that if account is taken of the social nature of knowledge then it might not be necessary to articulate what we know because 'it forms part of our knowledge context or cultural context of shared meaning' (p. 12).

These latter points indicate that the cognitive processes used by practitioners to decide what to do in practice situations should be explored.

#### **COGNITIVE PROCESSES AND PROFESSIONAL EXPERTISE**

Harrison's (1991) study into the cognitive processes of 'skilled practitioners' in social care settings in the UK drew heavily on Argyris and Schon's (1974) earlier work to address how practitioners make sense of the world in order to change it. Harrison differentiated between 'espoused theory' taught on professional courses (the textbook versions, similar to Fook's 'formal theory') and 'theories of action' (or 'theories in use') as guides or sets of steps about how to control or change a situation into one that is more desirable. These theories of action are usually tacit and internalised, and evolve through received 'practice wisdom' and experience. Harrison defined three maps of action that practitioners used when faced with new practice situations:

- (i) *Comparison and classification*, the most fundamental approach found, consisting of ‘an artificial process of people making sense from earlier combinations, assessments and prior cognitive products of dealing with data and the environment’ (p,74);
- (ii) *The use of generic theories of social work practice*, usually in the form of ‘unitary’ or ‘systems’ approaches, which ‘assumes that social work is one thing, differentially manifested, and that its targets and those for whom social work is undertaken can all be encompassed in one over-arching framework’ (p. 110);
- (iii) *Heuristic search and creativity in practice*, which derived from any of a wide range of sources and was characterised by openness to new or imaginative formulations.

These maps of action were not mutually exclusive, but were sometimes used sequentially or in combination. While this study was limited to 25 practitioners who were deemed to be ‘expert’ social workers, and so cannot be taken to represent the general population of social workers, some inferences from Harrison’s findings are worth elucidating:

- (i) The most prevalent map, *comparison and classification*, used a problem-solving strategy based simultaneously on firstly, a deterministic set of assumptions and secondly, on a social constructionist set. The first assumed regularities in the determination of particular variables such as people’s behaviours which when understood and then intervened into appropriately would lead to a predetermined result through a type of scientific reasoning. Secondly, and at the same time, social workers along with colleagues and clients ‘construct the classification scheme and build deterministic interactions as they work together’ (pp. 93-4). For Harrison, this confirmed the ability of practitioners to hold and work with conflicting paradigms of thought, to ‘juggle paradigms’:

Social workers’ capacities for integration of the positivistic and social constructionist epistemological dimensions were very evident in this study. While the integration would probably be thought of as extremely inconsistent and illogical to the scientist or philosopher interested in deciphering the logic involved in this integration of assumptions, the fact remains that the workers did it over and over with apparent ease. (p. 95)

- (ii) *Generic theories of practice* were often used when *comparison and classification* did not achieve the desired effect. Significantly Harrison noted that what his respondents described as generic theories did not correspond to the textbook versions, echoing the earlier studies cited:

... when derived from the ideas and experiences of practitioners, the construct of a generic theory takes on a somewhat different form ... What the workers say is not inconsistent with (the unitary approach ...) but *it is not so neat and clean, and it has a dynamic and changing quality*. (p. 111, my emphasis)

Secondly this use of generic theories was linked to practitioners’ beliefs (in this case, a belief in the value of community action). In other words, it fitted with their ideological positions. Accepting that ideology is present within any organised approach to social work

practice, nonetheless Harrison questioned whether it led to biases in practice, as ‘These workers were often willing to treat these ideological frameworks as knowledge frameworks grounded in fact, whether they had evidence or not’ (p. 123).

- (iii) The third strategy was used only when the former two been discarded, or used with unsatisfactory results, and was described by practitioners as ‘playing a hunch’ or taking a ‘leap of faith’. Heuristic practice is defined as ‘trying to solve problems both by trial and error and by using imprecise procedures, especially when a perfect solution is unknown or impossible’ (p. 126). The third strategy involved a search for creative, heuristic cognitive devices from any of a wide range of sources; a search for potentially helpful ideas from any source combined in new ways or ways new to the situation at hand. Using both ‘reframing’ and problem-solving, practitioners constructed new statements of the situation and new ways to change or adapt to it. Harrison draws on the metaphor of ‘common ground’ for the object of this search:

In this third cognitive approach to practice, the core of the applied idea might be the common conceptual ground between two or more situations ... A heuristic search leads to common ground based on the social workers’ knowledge and ability to extend and apply it creatively ... The ideas are used in new contexts rather than working within their boundaries and when necessary go beyond standard approaches. (p. 136)

This heuristic search though deemed by Harrison to be the essence of creative and responsive social work practice was used as a last resort by practitioners deemed to be ‘expert’ by their peers, and neither the learning nor developmental processes involved in its evolution are known. Nonetheless, Harrison’s work challenges Schon’s notion of reflection-in-action as a central tenet of professional practice, and suggests instead that professional practice in social work is more often concerned with fitting practice situations into known mental maps than creating new maps. Reframing situations or engaging in heuristic searches may occur only when situations are recognised as essentially unique and therefore requiring new solutions, or where practitioners are ‘stuck’ and searching for a solution.

#### **THE PROCESS OF THE DEVELOPMENT OF PRACTICE EXPERTISE**

Harrison’s study indicated that skilled practitioners evolve from a simple, straightforward and rule-oriented approach to more comprehensive and complex ones, a finding that Secker (1993) also noted in her study of the progress of social work students through training. Secker’s study complements Harrison’s. In her three approaches to practice (the ‘everyday social’, ‘fragmented’ and ‘fluent’) she found a progression: movement from initial use of ‘everyday social knowledge’, through a fragmented application of theory as ‘recipes for practice’ with depressing results, to the ‘ideal’ of a fluent approach. However, the number of students who were still practising a fragmented approach at the end of their training was double the number who had achieved a fluent

approach<sup>63</sup>. Secker's 'fluent' approach and Harrison's 'creative heuristic search' are, in fact, remarkably similar, consisting in the former case of the ability 'to creatively amalgamate different sources of knowledge' (Secker, 1993: 25), and in the latter 'a set of possibilities that intelligent practitioners borrowed from many sources, including scientific disciplines, humanities, previous experience and the experience of other people' (Harrison, 1991: 158).

#### THE DEVELOPMENT OF PROFESSIONAL EXPERTISE

Fook, Ryan and Hawkins (2000) have published the most comprehensive work to date on the development of social work expertise and have refined some of the hypotheses proposed by earlier studies in a rigorous longitudinal study<sup>64</sup>. Describing the social work ethos of practice as one which is 'contextual, complex, interdisciplinary, and value-based' (p. 14) and criticising existing studies for their concentration on cognitive processes at the expense of contextual factors, they aimed through the inductive analysis of the themes and issues raised by practitioners in their conceptualisations of practice:

... to describe and to develop a theory for the development of the practice which deals with complexities and uncertainties which are involved in making and taking value- and knowledge-based decisions and actions in changing situations. (p. 7)

While their study differed in methodology and focus<sup>65</sup> from my study<sup>66</sup>, both share an interest in contextual and cognitive aspects of practice, social constructionist and constructivist processes involved, and seek to access practitioners own conceptualisations of practice rather than impose preconceived concepts. There are also similarities in the themes and issues inductively developed from the practitioners accounts as will be discussed and analysed in later chapters.

Fook *et al.* analysed the practices of participants at different points in their education and first three years of practice and compared them to findings from a separate sub-study into the practice of practitioners deemed expert by their peers. They critique the emphasis on the *generalisability* of transfer of knowledge for its lack of recognition of the contextually-bound nature of practice, and consider the concept of *translation* of knowledge from one situation (and context) to another as superior to the concept of universal application. They propose that professional expertise needs to be considered as a set of principles for *contextual knowledge creation and translation*.

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<sup>63</sup> Out of a total sample of 21 students interviewed three times prior to and during their social work education, only six had achieved a 'fluent' approach, whereas another twelve were still practising in a 'fragmented' way (Secker, 1993).

<sup>64</sup> This Australian work consisted of four inter-related studies: a five year longitudinal study of 39 students from the beginning of their 2 year training, to the end of 3 years in practice (30 at end); a study of 30 'expert' practitioners nominated by colleagues; a comparison group of 16 community development students from another course; and a comparison with a third group of students from another social work course. Data collection took place between 1990-1995.

<sup>65</sup> Being premised on the processes of developing expertise throughout professional training and in the first three years of practice, and being longitudinal in nature.

<sup>66</sup> Being premised on the processes involved in transferring knowledge from a post-qualifying short course to practice, and deriving data from one point in time.

They noted the changes that occurred over time for their research subjects.

During the first year of practice, participants were often struggling to cope with new (first time) situations and challenges. By the second year of practice, participants realised that they could be effective with ‘a markedly more positive flavour about the second year of practice’ (p. 160). The authors suggest that the two-year point was a watershed – a sufficient period in which to consolidate skills and confidence. By the third year of practice, however, there was a noticeable shift of mood:

... the negativities of work become more apparent, perhaps partly depending on the context of their practice. Practice concerns were much more negative, and the themes of burnout, stress, frustration and disillusionment were striking. (p. 160)

Noting that some dimensions of experienced practice did not fit with notions of ‘good’ social work practice<sup>67</sup>, Fook *et al.* theorised that not all experienced practice is expert and that conversely, one might be able to engage in expert practice without having long experience:

‘there is a need to differentiate between professional practice which is good simply because it is well practised, tried and tested, and that which is good because it achieves new standards, or is effective in new situations which do not meet the norm’ (p. 179).

In social work, they argue, the expert needs to be prepared to contend with ill-defined problems, and the expert practitioner

... is one whom we would expect can take risks, and act beyond the call of duty ... reaching the expert stage may involve factors such as an openness to new ideas, a preparedness to think creatively, a frame of reference which frames problems in complex as opposed to routine ways (p. 180),

and that involve creativity and flexibility. Experts approach situations with a focus on the *process* rather than specific *outcomes*. They consider a range of options and do not limit themselves to formulaic options, but create new alternatives as the situation demands. The principle of flexibility has implications for use of formal theory at different developmental stages, because

‘novices tend to take a rule-based approach to theory, applying it deductively in new situations ... a more complex, less rule-based and less linear or deductive approach characterises more experienced or expert practice’ (p. 189),

a point supported by the work of Harrison (1991) and Schon (1983).

In relation to the use and creation of knowledge, Fook *et al.* suggest that

... the ability and willingness to use particular knowledge is affected by *work context, the way knowledge is introduced, and the way it is linked to professional concerns*’, and that from this point of view ‘the knowledge and theory that expert professionals create may simply be the reworking of more formalised, abstract theories, *for its relevance in specific*

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<sup>67</sup> Such as the tendency to individualise problems and the growth of a ‘social distancing’ phenomenon.



*professional contexts, and the processes by which it is reworked and introduced to professionals may become paramount.* The implication of this is that professional knowledge created from practice, may be the only knowledge which is used by practising professionals, because it is the only knowledge which is regarded as ‘functionally relevant’. (p. 192, my emphasis)

These suppositions raise specific questions for my study: namely to what extent do work context, the way knowledge is introduced, and the way it is linked to professional concerns, influence the reception of a practice method introduced through a short training course?

The significance of context was also scrutinised. Fook *et al.* distinguish between statutory or government settings and non-government settings. 10 of their 30 respondents worked in statutory child protection settings and, after elaborating on the specific nature of the local context<sup>68</sup>, they note that ‘many of the workers located in this setting appeared to be in danger of falling behind their colleagues in the non-government sector in terms of social work skill and knowledge development’ (p. 171). By the end of the third year of practice, the differences were marked.

First, there were those (predominately working in government settings) who appear overwhelmed by the bureaucratic constraints of their work, and tended to respond in programmed, less spontaneous ways to problem situations. It is as if being constantly limited by bureaucratic restrictions, they in turn become less able to approach new practice problems in creative ways ... By contrast, another group of workers (workers in largely non-government settings but not exclusively) made conscious choices about whether or not to conform to bureaucratic guidelines and take a more critical stance ... It was this group which, although possibly feeling frustrated, were less likely to burn out. There was a sense in which these workers had internalised, or taken responsibility for, their own learning and actions, and therefore felt less constrained by their work environment. (pp. 171-2)

Furthermore, the less skilled group from predominately government settings

... might be seen as more ‘programmed’ workers ... characterised by an apparent concern with dealing effectively within a bureaucracy, rather than the broader welfare of the client. Whilst they might hold a critical view of the ‘system’, as do some in the more skilled group, these workers tended to see themselves as ‘victims’ of the system. (p. 172)

The workers from non-government settings also differed in their orientation towards the work, were in general more holistic, and recognised that contextual elements were integral to relevant practice in a situation. Workers in government settings in contrast ‘tended to be much more minimalist in their orientation as they were constrained by the statutory focus of their work; this meant that they were less contextual in their orientation to their work and clients’ (p. 173).

Fook *et al.*’s work raises the question of whether workers in different settings, and at different points in their development, vary in their response to the introduction of a new practice method,

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<sup>68</sup> ‘Child protection work [in this locality of Melbourne, Victoria] ... has become highly specialised. The whole focus of their work has become one of investigation and protection. In the past, child protection work was a small part of a worker’s caseload, which gave them the opportunity to work with a range of clients in a variety of contexts and enabled them to see the broader context within which child protection functions. This gave them the chance, which is now largely denied them, to develop a range of skills and knowledge and reduce the stress associated with working with a narrow child protection focus’ (p. 171).

and also whether they will interpret it differently. For example, will workers in child protection setting adopt in a more minimalist manner and adapt it to fit with the perceived constraints of a statutory setting, and will workers in other settings also tailor (or re-invent) an approach to suit the perceived requirements of *that* setting?

Fook *et al.* define context rather broadly in relation to type of work setting and do not address local factors at the team and local area level which may influence the progression of individual workers' development within specific work contexts. This is primarily due to the research design which tracked individuals from courses rather than identifying and analysing clusters of practitioners. My study will endeavour to incorporate local factors into the analysis.

### **THE SOCIAL WORK ETHOS AND FORMAL THEORY**

Banks (1995) has provided a thorough review of the values underlying different theories and perspectives which have been promoted in social work, and their compatibility with the stated values of social work. In her analysis, most of the knowledge (theories, models and techniques) proposed for social work do not fit easily with the values of social work, as the former

‘tend to presuppose a view of human thought and behaviour as causally determined – by unconscious psychological factors, by natural instincts, the social environment or by social and economic structures’ (p. 66)

and the latter are ‘based on the notion of the user as a person who is free to make choices and to determine her or his action according purposes and goals’ (p. 66).

She suggests that this lack of fit occurs for three reasons:

- firstly because clients are usually people experiencing difficulty and so can be viewed as temporarily less capable of rational decision-making than those not experiencing difficulties;
- secondly because of the structures within which social workers operate such as legal requirements, agency policies, time and resource constraints, and bureaucratic procedures; and
- thirdly because the preoccupation with establishing its place and status as a profession has privileged positivistic rather than humanistic approaches.

Banks concludes that

‘the theories and perspectives which are closest to the traditional social work values – the humanist, and to some extent, the cognitive – are both under-developed as comprehensive theories for social work practice’ (p. 61).

The humanistic perspective based on the work of Rogers (1957), emphasises the importance of the relationship forged between worker and client. The “core conditions” of empathy, unconditional positive regard and a non-judgemental stance are seen to fit with social work values of self-

determination, acceptance and respect for the individual. Banks suggests that the humanistic approach is not more widely developed as a comprehensive approach for social work because

... the location of social workers in bureaucratic agencies with social control functions is not conducive to the approach of humanist therapies where users are in control of the exploration and the worker has a non-directive role. (p. 60)

Cognitive approaches, which are concerned with people's thinking, which assume that people's behaviour is directed by thought appear to have gained more favour among social work practitioners. When combined with humanistic elements, cognitive approaches are seen to be congruent with the values of self-determination and the enhancement of functioning.

Payne (1991) concurs with this view of the consonance between cognitive/humanist approaches and social work values. Cognitive approaches in his view offer

... a useful way of understanding social work in a way that emphasises clients' rational capacity to manage their own lives, and enhances that capacity with clear and well-trying techniques. Allied with humanist views of the process and related values which respect and involve clients, cognitive approaches ... retain many of social work's basic caring values within a framework of effective action. (Payne, 1991: 200)

SFT as a practice method has been considered to fall within the cognitive-behaviourist field, although as already noted others have variously viewed it as social constructivist or humanist/existential in nature. There is a possibility that SFT might appeal to different constituencies of social workers depending on *how* it is perceived. My study will examine how SFT is perceived and which features are identified and emphasised by practitioners, in other words: what ideas, concepts, and values do they take from SFT?

Parton and O'Byrne (2000) have recently argued for a re-conceptualisation of social work, as neither *technical-rational*, nor *reflective-practice* endeavours, but as a *practical-moral* enterprise. Emphasising the value-laden and ambiguous nature of social work, they maintain that constructionist approaches to practice (including SFT and Narrative approaches) provide the most hopeful bases for constructing new practice theories, because 'Far from denying the ethical and moral dimensions of the work, it makes them central' (p. 178).

This view however, is very different from the origins of SFT<sup>69</sup> which in its initial conceptualisation as a framework for practice in therapeutic settings, made no attempt to engage overtly with the contested and ambiguous nature of the helping enterprise or to examine the power relations between helper and helped. This point will be elaborated in the next chapter on SFT.

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<sup>69</sup> The same cannot be said however of Narrative therapy, which has been identified as an 'exemplar of attempts at Foucauldian therapy ...[and] which follows Foucault in suggesting that most people's stories draw on the dominant discourse' (Foote & Frank, 1999: 177).

Parton and O'Byrne's 'constructive social work' places morality at the centre of the social work enterprise and draws on SFT and narrative approaches to create the notion of the practitioner as an actor in the process, who does not deny issues of power relations and oppression, but who

... continually problematises and questions what is taken for granted and hence tries to open up creative ways of thinking and acting. The focus is on the human being's continual attempt to make sense of and change the world and the central role played in this by talk and language. The active agency of the individual in their social/relational contexts is prioritised. (p. 178)

The development of this theory is relatively recent. Its appearance signals the impact and the increasing centrality of social constructionist/ constructivist ideas for the profession in these times.

### **THE POLITICS OF THEORY**

From the accounts of practice and empirical studies examined above, it is apparent that certain theories or models gain particular favour at certain times: The largest DHSS study (1978) cites task-centred work; contract work and 'in-depth' therapeutic work as three models identified in the social services teams studied; Harrison (1991) found that community-action models were in favour; Fook *et al.* (2000) examine the primacy of concepts and practices of systems theory and 'social justice' within their study. Butler (1996) describes the strengths perspective, solution-focused therapy and motivational interviewing as being the dominant modes of intervention in the field of addictions in Ireland in the mid-1990s.

Within any field of practice, different models become 'fashionable' and peak at particular times, perhaps because they are seen to offer something new; or fit with what managers or administrators are anxious to promote; or because they appeal to particular constituents within an occupational group. These models are subsequently replaced by newer theories, or adaptations of older ones, which appear to fit better. Ideally such an evolution indicates that formal theories and practice realities interact in a reflexive manner. The politics of theory as outlined by Payne (1997) suggests that proponents of particular approaches compete to achieve acceptance and status for their model.

[This] struggle for acceptance of a 'theory' intends to gain a greater contribution for it in the overall construction of social work, by gaining greater impact for it in workers' actions within social work as they daily construct it with their clients in their agency contexts. (Payne, 1997: 3)

Howe (1991) has gone further than naming the process, and has called for a sociology of social work method, as we need to

... consider the relationship between a particular practice, the times in which it lives or dies, and the context in which it does well. The comings and goings of different methods will then seem less random as we discover that methods are shaped by, and themselves shape, the ideological currents of our time. (p. 148)

The politics of theory, and the need for a sociology of social work method, suggest that analysis of any method needs to identify and address the contextual factors which contribute to, or create

obstacles for, the adoption of that method, and the meanings attributed to particular methods by different actors.

Ideas have their time and place; they are shaped by whatever intellectual currents prevail. Particular styles of thought, knowledge, and concepts cannot be entertained by anyone at any time. They form because the time is right and their time has come, and in a broad sense we all think in a particular way at a certain time. At some deeper level, then, these are times which generate ideas which, when they surface, look superficially unconnected. This is not so. (Howe, 1991: 162)

## CONCLUSION

Empirical studies of the practice of social work reveal the interplay of a variety of factors which determine the shape that social work practice takes in particular contexts and times.

The effects of *contextual* influences, such as the role of the team leader, the agency function, the bureaucratic nature of some agencies and wider socio-political influences have been established. Research suggests that at an *individual* level, workers vary in how they approach similar pieces of work, independently from such other influences as agency function, direction of manager, and workload levels. The generalisability of these findings need to be tempered with a recognition that social workers employed in particular fields of practice, such as child protection, may have decreased professional autonomy due to the increasing bureaucratisation of practice but that practitioners in general do retain control over the style of practice.

Classifications or taxonomies of various orientations or types of social work have been proposed (Howe, 1987; Payne, 1997) and social work theorists exhort practitioners to identify their ideological/ philosophical position because perception, cognition and action are seen to be inextricably linked. Yet the presumption that a practitioner's theoretical orientation is either fixed or one-dimensional is not supported by empirical studies into social workers' practice. Orientation may at best be an approximation of how a practitioner is approaching any one case.

Studies of the use of theory by social workers suggest that practitioners do not adopt methods in a linear, positivist fashion but generally draw on particular models and frameworks for ideas and concepts on how they might intervene in particular practice situations. Expert workers have been found to be adept at 'juggling paradigms' and at borrowing and adapting aspects of particular practice models to fit what is required in a given scenario. Practitioners display differing approaches to the use of specific practice models depending on their level of expertise and developmental stage of acculturation into the profession: new graduates are more likely to adopt a 'recipe' approach and more experienced practitioners are likely to draw on a range of methods and influences according to their own personal models developed over the course of their work experience. Experience alone does not appear to provide expertise. The components of expert practice including the abilities to be flexible, creative, work with uncertainty and complexity, and

develop context-specific rules which can be translated to new practice contexts, may derive as much from individual ability as from progression over time.

The social work ethos or value base is of importance to practitioners as it provides a moral guide with which to negotiate complex practice situations. Theories promoted for social work however vary in their congruence with social work values. The social work ethos in itself is also potentially compromised in bureaucratic agencies with social control functions, as the regulatory function of social work may dominate and marginalise the welfare or therapeutic aspect.

The politics of theory suggest that advocates of particular approaches will compete and make claims in order to 'win ground' for that approach. There needs to be a particular constellation of events and ideas coalescing for particular methods to gain in popularity.

The following chapter will consider the evolution of SFT and how it gained its recent popularity in the helping professions.

## **CHAPTER FOUR: SOLUTION FOCUSED THERAPY**

### **INTRODUCTION**

Before embarking on an examination of SFT itself, it is necessary firstly to consider the background of ‘therapy’, ‘family therapy’ and ‘brief therapy’ from which it emerged; and secondly to contextualise SFT in relation to both its roots and its emergence as an increasingly popular approach at a specific point in time: the 1990s. Thirdly, the research literature pertaining to SFT will be summarised and reviewed.

The literature regarding the use or potential use of SFT in social work will be critically reviewed and some tentative hypotheses suggested regarding its place in social work practice.

### **(I) BACKGROUND TO THE DEVELOPMENT OF SOLUTION FOCUSED THERAPY**

#### **Therapy**

There are basically two ways of accounting for the emergence of the psychological therapies around the late eighteenth and early twentieth centuries. One explanation points to advances in psychiatric and psychological knowledge that led to the discovery of this new form of treatment. From this perspective, therapy can be seen as part of the ‘technology’ of psychology and psychiatry...The other approach to explaining the rise of therapy looks not forward with science and progress but backward towards some very old cultural traditions. From this perspective, all cultures possess ritualised ways of enabling members to deal with group and interpersonal tensions, feelings of anger and loss, questions of purpose and meaning. These rituals evolve and change over generations, and are part of the ‘taken-for-granted’ fabric of everyday life. Looked at in this light, psychotherapy can be viewed as a culturally sanctioned form of healing that reflects the values and needs of the modern industrial world (McLeod, 1997:1 – 2)

‘Therapy’, ‘psychotherapy’ and ‘counselling’ are now common currency in the lexicon of the individually-focused helping professions and are widely used to denote different forms of intervention with individuals, couples, families and groups. They are most commonly employed in developed Westernised societies where the satisfaction of basic human needs for the majority of populations is thought to have been achieved<sup>70</sup> and where attention has shifted to emotional needs. Practice in social work or therapy is predicated on Western belief systems centred on individual needs and rights and derived from the Judeo-Christian ethos and the capitalist mode of production. Its relevance to non-Western contexts and cultures has been rightly questioned (Payne, 1997; Graham, 1999).

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<sup>70</sup> but this may not necessarily have happened.

There are now literally hundreds of different approaches to psychotherapy and counselling<sup>71</sup>, and they are classified in varying ways. While ‘therapy’ has become popular and can be defined as a form of talking cure which aims to assist people with individual problems, it has not become the exclusive domain of any one profession.

What we call counselling or psychotherapy is rightfully owned by lots of different professions, disciplines, fields, each of which can state their rightful claims to legitimate ownership. (Feltham, 1995: vii)

Social work, then, is not the only profession to claim legitimate engagement in therapeutic endeavours. It is one of many.

Therapy, however, has remained a contested term within social work discourse, due in part to the pervasive influence that psychoanalytic and psychodynamic theories are seen to have had on social work’s development (Howe, 1987; Payne, 1997) but also due to the debate on whether social workers should focus on individual change or collective action. Compton and Galaway (1994) suggest that the association of social change with community organisation and of individual change with social casework may oversimplify social work

... inasmuch as work with individuals can be directed towards change in social standards and work with groups or communities can be directed towards helping people adapt to their current situations. (p. 7)

A robust defence of the case for individual change-work with clients is made by Barber (1991) who draws on Freire’s (1972) notion of ‘the pedagogy of the oppressed’ and on the concept of ‘learned helplessness’ (Seligman, 1975) to argue that clients who suffer oppression may need to be motivated and energised on an individual level before they can consider taking on structural inequalities.

The influence of psychoanalysis is feared to have led to an image of the social worker as

... a psychoanalytic caseworker, steeped in Freudian psychology ... who talks about potty training experiences with the client while above the roof leaks, at the door the rentman shouts for his money, and all around run children without winter coats. (Howe, 1987: 79)

While this image of a social worker may now be mythical, it is also the case that a number of social workers actively subscribe to a narrow clinical or therapeutic role<sup>72</sup>. While some social workers with further training move into the fields of counselling and psychotherapy and abandon the role of social work, many social workers have borrowed psychotherapeutic concepts, practices and techniques to develop further a practice which has remained within the social work tradition.

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<sup>71</sup> The terms ‘counselling’ and ‘psychotherapy’ are often used interchangeably and appear to be derivatives of cultural differences as much as anything else. The distinction between counselling and therapy becomes more spurious when one examines the different meanings attributed to both: for example, much of what is called counselling in the UK and Ireland would be called therapy in the USA.

<sup>72</sup> albeit one which is not now exclusively psychoanalytical in emphasis



The case for therapy in social work also depends on the construction of therapy, or psychological change-work: does it denote the worker as 'expert' who knows what is best for the client and how to fix it, or can therapy, be conceptualised in a different way, to connote the worker as collaborator who works with a client to co-construct new ways of talking, understanding and doing?

One therapeutic field which has been of particular significance to social workers has been that of family therapy.

### **Family Therapy**

SFT was developed in a family therapy setting in the USA in the early to mid 1980s, a particular context at a particular point in time.

A review of the development of family therapy as a particular discipline in the years 1960-1980 indicates a dynamic and ever-changing development of ideas focused on a family orientation. Initially linked to psychoanalytic thinking, it became more centrally influenced by systems thinking and communication theory, which primarily emerged from the USA but with some related contemporaneous developments elsewhere. An ever-increasing range of approaches in the 1970s widened its popularity and influence beyond the USA, primarily through individual, charismatic and gifted therapists who became international celebrities such as Salvador Minuchin and Virginia Satir. As the field became bigger and more complex, attempts to classify different approaches met with varying degrees of success, with one author by the mid 1980s admitting defeat: 'It is said there are as many ways of practising family therapy as there are workers in the field' (Burnham, 1986: 62).

The emergence of family therapy as a popular method of intervention in the latter part of the twentieth century can be traced to:

- (i) The dominance of individual charismatic leaders or 'pioneers' and their particular brands of therapy;
- (ii) The importance of workshops and conferences featuring live and videotaped demonstrations; and
- (iii) The lack of attention paid to outcome and consumer studies.

The characterisation of 'change merchants' as pioneers in the family therapy movement has been criticised for the superficiality it engenders:

For nearly half a century family therapists have had a tradition of being pioneers, but we have to face the fact that this is now an old-fashioned idea. We pay a very high price for our pioneering glory as every new idea proposed has to flag new territories, new discoveries. This means that 'not new ideas' are discarded, so instead of weaving an even richer and deeper understanding of families that thinking becomes as superficial (or profound) as the newest fashion. Worst still, no fashionable 'pioneering' ideas can be seen to come from other disciplines, such as developmental or cognitive psychology or individual therapy, or their research data although many so-called 'new' ideas, such as

narrative, have been explored by other disciplines well before we ‘discovered’ them’.  
(Byng-Hall, 1998: 139)

This criticism echoes one point made in the previous chapter regarding the ‘politics of theory’ – the extent to which advocates of particular models may vie for an increased position of power and may exaggerate claims for the effectiveness or superiority of their particular brand.

### **Critiques of Family Therapy**

In relation to family therapy generally, there has been concern that claims for its effectiveness have been overstated. Criticisms have also focused on its lack of user-friendliness (Howe, 1989; Reimers & Treacher, 1995). One analysis (Gurman, Kniskern & Pinsof, 1986) which claimed that outcome studies supported the efficacy of family therapy was critically scrutinised (Reimers & Treacher, 1995) and different conclusions were reached.

Firstly, Reimers and Treacher found that, with the exception of behavioural and psycho-educational models, claims for most family therapy models were not supported by empirical findings; and secondly, that many of the major theorists of the time (such as Satir and Whitaker) had shown ‘remarkably little interest either in validating their results or recording what their users experience when they are at the receiving end of therapy’ (p. 21). Reimers and Treacher concluded that there was little evidence that therapists are attracted to particular models by their demonstrable efficacy: ‘the attraction of the model is at a personal and not a rational-scientific level’ (p. 21). This, they relate to features associated with the development of the family therapy movement itself which:

... has been disproportionately shaped by the influence of charismatic leaders performing (literally) as showmen at important conferences and workshops ... apparently highly effective interventions are demonstrated by skilful practitioners who are excellent showmen. Failures are typically not shared and there is usually little attention paid to research findings. Many of the presenters of such workshops actually earn their living from their presentations so there is often an in-built marketing factor which militates against presenters being objective about their own successes and failures. (Reimers & Treacher, 1995: 24-5)<sup>73</sup>

Reimers and Treacher concluded that changes were needed if family therapy was to fulfil its potential as an ethical and effective practice. In particular, they argued that more attention should be paid to the user’s perspective and less to a fascination with versions of systems theory which rendered the user invisible and were ‘anti-humanistic’ in orientation. They identified some developments within the family therapy field from the mid-1980s onwards as hopeful, particularly those related to the development of ‘second-order’ approaches (Hoffman, 1990, 1991)<sup>74</sup> and feminist critiques of family therapy<sup>75</sup>.

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<sup>73</sup> This analysis and critique of the family therapy movement up to the mid-1990s is of some importance because the authors were both practising family therapists with a commitment to the approach.

<sup>74</sup> ‘Second-order’ approaches can be characterised as those which question the expert position commonly adopted by family therapists; which emphasise the importance of meaning and beliefs; and of the process

## **Brief Therapy**

A key ongoing debate in the field of therapy has focused on the length of treatment and the relative efficacies of short-term versus long-term approaches.

As early as the mid-1950s, psychiatrists and family therapists such as Erickson, Weakland and Haley were using brief treatment approaches, although these had not yet been formalised into models for practice (Haley, 1973; Erickson, 1954). Long-term work was seen to be expensive; demanding for practitioners and clients; and risked creating problems of dependency for the client to resolve when the therapy neared an end. There were fears that long-term therapy could become directionless and that motivation, thought to be highest at the initial crisis point of seeking help, would dissipate in longer-term treatments.

The growth of the 'short-term movement' in both psychotherapy and social work is thought to date from the late 1960s and early 1970s<sup>76</sup> and four factors have been identified which contributed to its advance:

- (i) Disillusionment with psychoanalytic dominance in psychotherapy and social work and lack of evidence of its effectiveness.
- (ii) Client choice: Research results indicated that, clients tended to stay in therapy for only 6-10 sessions (Reid & Shyne, 1969; Garfield & Bergin 1978; Koss, 1979) and preferred brief interventions. Reid and Shyne's (1969) study of Brief and Extended Casework confirmed that a significant number of social work clients tended to leave treatment after ten sessions and were less likely to engage initially if offered open-ended treatment.
- (iii) Evidence of the effectiveness of brief methods: Reid and Shyne found that those receiving brief treatments achieved significantly more positive change than those receiving the open-ended service. Research evidence on the impact of the first 6-8 sessions (Reid & Epstein, 1972); and that changes made in short-term treatments are at least as durable as those in longer-term interventions (Reid & Shyne, 1970; Fisher, 1984) strengthened the appeal of brief methods.

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within sessions, particularly styles of questioning, as opposed to the importance of the construction of tasks and interventions at the end of sessions (Reimers & Treacher, 1995).

<sup>75</sup> Feminist critiques have 'added a more direct, certain and down-to-earth challenge ... in particular, it has challenged the failure to address serious issues of power and inequality' (Reimers & Treacher, 1995: 192). Hare-Mustin (1978) and Goldner (1985) were two influential early feminist family therapists.

<sup>76</sup> Although it must be noted that in the case of social work, there is evidence of experimentation with brief methods prior to the 1960s. Reynolds (1932) is an example of experimentation with 'short-contact interviewing' which equates strongly with brief therapies and single-interview interventions. Her conclusions following a period of time experimenting herself with single-interview contacts are worth noting: 'While there is an immense amount of research to be done on this question, the writer is convinced that students can be trained from the beginning to use their eager curiosity about life, their ability to gain skill in observation, their flexible imagination and ready sympathy in such a way as to get the essential things to know about people, at least for a start towards a working relationship, in shorter time than with the old agency-centered, worker-protective, and worker-glorifying methods' (p. 101).

- (iv) Cost-effectiveness – regarded by some as the most compelling argument in favour of short-term interventions; and clearly of relevance to all those publicly and voluntarily funded organisations who attempt to provide services on tight budgets. (Barker, 1995)

These four factors contributed to a climate where short-term intervention models began to gain in popularity from the early 1970s onwards, not only in family therapy but also in the related fields of counselling and social work.

The question of ‘lasting’ versus ‘superficial’ change, as Payne (1997) notes, continues to percolate through the helping professions, reflecting the influence of in-depth work favoured by psychoanalytically-oriented practitioners. This view is less prevalent since the publication of numerous studies indicating that lasting change can be achieved by short-term cognitive and behavioural or combination therapies. McKeown *et al.* (2001) conclude that ‘in general, research results are inconclusive on the relationship between length of treatment and outcome’ (p. 31). The difficulty being presented for treatment, together with issues of motivation, ability and goals are important factors (Asay & Lambert, 1999).

### **Brief strategic therapy**

Brief Therapy, existed before de Shazer’s SFT model was developed but brief strategic therapy should be distinguished from other forms. While some brief therapies are psychodynamic in nature ‘brief therapy’ has increasingly become associated with strategic or ‘post-strategic’ approaches.

Strategic therapy has been defined as a combination of

... a communication systems approach, the use of paradox and the strategic wizardry of Milton Erickson. Together these provide a framework for bringing about change in a system. The focus is directly on the presenting symptoms, the reality of the problem is defined as narrowly as possible, and strategies of intervention are planned. (Guerin, 1976: 20)<sup>77</sup>

Bateson<sup>78</sup> and Erickson<sup>79</sup> contributed to the development of strategic therapy in particular ways. Erickson’s work, carried out in the 1940s and 1950s, was ‘uncommon’ for the time, especially when viewed against the prevailing psychodynamic orthodoxy.

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<sup>77</sup> While this is a somewhat dated definition, it is the most useful for the purpose of comparison here as it summarises the main feature of the approach as understood and practised in the 1970s and 1980s and precedes some of the later splits within the strategic field.

<sup>78</sup> Gregory Bateson, an anthropologist, contributed through his work on communication in the 1950s. In particular, his identification of the circular nature of communicative interaction; the notion of paradoxical communication; and the importance of language and description as being only partial and subjective explanations of reality, played an important part on the development of systemic approaches to problems (Burnham, 1986).

<sup>79</sup> Milton Erickson, a psychiatrist practising in Phoenix, Arizona in the 1940s and 1950s, and whose ‘strategic wizardry’ is referred to above, is viewed as having an immense influence: ‘It is not possible to overestimate the influence of Milton Erickson on the development of brief/strategic approaches’ (Cade & O’Hanlon, 1993: 1).

His theory of change is more complex; it seems to be based upon the interpersonal impact of the therapist outside of the patient's awareness, it includes providing directives that cause changes in behavior and it emphasises communicating in metaphor. (Haley, 1973: 39)

In these ways it was the first formulation of a strategic therapy.

The Mental Research Institute (MRI) founded by Don Jackson in Palo Alto, California in 1959, brought together some of the original members of Bateson's communication project team, such as Haley and Weakland, and incorporated ideas from Erickson's uncommon techniques to establish The MRI Brief Therapy Project. Their brief strategic approach was outlined in two major publications in 1974: a book entitled '*Change*' and a paper in the journal *Family Process: 'Brief Therapy: Focused Problem Resolution'* (Watzlawick *et al.*, 1974; Weakland *et al.*, 1974). These publications were based on six years work with families developing brief methods of intervention with families.

Defining brief therapy as (i) focusing on observable behavioural interaction in the present and (ii) involving deliberate intervention to alter the ongoing system, the MRI group claimed to have developed a new conceptualisation of the nature of problems as well as their resolution. Brief therapy in this mould was characterised by the absence of any 'elaborate theory of personality or dysfunction' and relied instead on simple diagnostic formulations which would allow therapists to intervene as briefly and effectively as possible (Cade & O'Hanlon, 1993: 5). It was based on the premise that the types of problems people bring for treatment persist only if they are maintained by ongoing behaviour of patients and others with whom they interact (potentially including the therapist), and secondly that the problematic behaviour or thinking is not in itself a symptom of a deeper systemic dysfunction. Thus brief therapy becomes a treatment of choice rather than dictated by practical and economic considerations. The role of the therapist became that of an active agent of change – whose aim was to intervene 'to alter poorly functioning patterns of interaction as powerfully, effectively and efficiently as possible' (Weakland *et al.*, 1974: 145).

'Brief Therapy', as it is referred to now in the professional literature, generally describes either the Mental Research Institute (MRI)<sup>80</sup> model of brief strategic therapy (Weakland *et al.*, 1974) and/or de Shazer's solution focused approach or derivatives of these<sup>81</sup>. Including some but not necessarily all of these variants, it is now generally accepted as an evolving but specific mode of therapy which

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<sup>80</sup> The Mental Research Institute in Palo Alto, California, was founded in the late 1960s, and headed by a number of eminent family therapists of the time, including John Weakland and Paul Watzlawick. The Brief Therapy Project there developed a model of brief therapy subsequently called the MRI model.

<sup>81</sup> Derivatives include the 'solution-oriented' approach (O'Hanlon & Weiner-Davis, 1989), solution-oriented, competency-based 'integrative' brief therapy (Hoyt, 1994), 'therapy with impossible cases' (Duncan, Hubble & Miller, 1997). Although not direct derivatives, Narrative Therapy (White & Epston, 1990) and 'Single-session' therapy (Talmon, 1990) are sometimes also included.

is applicable to individual, couple and family work in a variety of settings (Miller, 1997; Cade & O'Hanlon, 1993).

*Brief Therapy* in its current incarnation can be defined as a therapy which:

- a) which concentrates on promoting change rather than promoting growth, understanding or insight;
- b) where the therapist is instrumental in bringing about change;
- c) which uses the term *interactional* rather than *systemic* to denote sequential contact between people; and
- d) which:

... is essentially concerned with observable phenomena, is pragmatic and related to the belief that problems are produced and maintained 1. by the constructs through which difficulties are viewed, and 2. by repetitive behavioral sequences (both personal and interpersonal) surrounding them ... (which can) ... include the constructs and inputs of therapists. (Cade & O'Hanlon, 1993: 5)

### **The components of therapeutic effectiveness**

Research meta-analyses<sup>82</sup> now show rather conclusively that therapeutic effectiveness rests not so much in particular models or techniques but in core factors in the therapeutic encounter, known as 'the Big Four' (Hubble, Duncan & Miller, 1997: 8). Duncan (2001) notes that

The uncomfortable truth for advocates of these verified treatments [empirically supported treatments such as cognitive-behavioural therapy] is that there is no solid evidence demonstrating that specific treatment models have unique effects, or that any single therapeutic approach is superior to another ... studies have yet to show consistent differences in effectiveness among therapies developed to address a particular problem despite the Herculean efforts of legions of researchers to do just that. (p. 31)

Reviewing the international evidence for their research study of the effectiveness of marital counselling in the Irish context, McKeown, Haase and Pratschke (2001) outline four common factors which previous generations of studies have identified:

- (i) client characteristics and social support
- (ii) therapist-client relationship
- (iii) client hopefulness; and
- (iv) therapeutic technique.

*Client characteristics/extratherapeutic factors* may be static (such as sex, family background) or dynamic (behaviours, attitudes) and the quality (and quantity) of support networks. Estimated to account for 40% of outcome variance (Hubble, Duncan & Miller, 1999), 'this hefty percentage represents a departure from convention, considering ... much of what is written about therapy celebrates the contribution of the therapist, therapist's model, or technique' (p. 9). It also

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<sup>82</sup> Reviews which provide an overview and analyse a number of studies relating to a particular field.

... underlines the importance of understanding what clients bring to therapy and how these attributes might be used to promote change ... every individual, every couple and every family has strengths, abilities and resources to cope with and overcome their problems and this, in turn, is central to the strengths-based approach to working with families and couples. (McKeown *et al.*, 2001: 25)

*Therapist-Client Relationship*: Following on from the emphasis placed by Freud and Rogers on the importance of relationship,

There seems to be widespread agreement that the eventual therapeutic outcome is strongly influenced by the quality of the relationship between the therapist and the client whatever the kind of treatment offered ... a growing number of studies has found that clients' rating of the therapeutic alliance, rather than therapists' perceptions of that relationship, are more highly correlated with outcome. (McKeown *et al.*, p. 28)

Quoting Lambert's original work (1992), Hubble *et al.* (1999) note that it accounts for 30% of outcome variance, and

'represent a wide range of relationship-mediated variables found among therapies no matter the therapist's theoretical persuasion. Caring, empathy, warmth, acceptance, mutual affirmation, and encouragement of risk-taking and mastery are but a few' (p. 9).

Studies of social work have identified the extent to which lack of agreement between worker and client regarding goals and lack of attention paid to explicit agreement making in the initial stages of contact can detrimentally affect outcome (Sinclair & Walker, 1985; Mayer & Timms, 1970; Maluccio, 1979).

*Client Hopefulness* – indicates the importance of considering the climate of the encounter between client and helper. McKeown *et al.* note that

The importance of engendering hope and enthusiasm underlies the view that individuals, couples and families seek help not when they develop problems but when they become demoralised with their own problem-solving abilities ... An important implication of these findings is that therapy can restore hope, *particularly if therapists have a hopeful attitude towards their clients.* (p. 29, my emphasis)

Placebo, Hope and Expectancy were gauged by Lambert (1992) to account for 15% of outcome variation. Snyder *et al.* (1999) developed a cognitive theory of hope which stresses the importance of helpers remaining hopeful. In their view, therapists must have hope that clients can change. Furthermore, 'therapists who are burned out or otherwise fail to convey hopefulness to their clients implicitly model low agency and pathways thinking'<sup>83</sup> (Snyder *et al.*, 1999: 183). Hope as a component of social work practice is, arguably, more complex than in the field of therapy. For

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<sup>83</sup> 'Hope may be understood in terms of how people think about goals. Thinking about goals is defined in two components. First there are the thoughts that persons have about their ability to produce one or more workable routes to their goals. And second, there are the thoughts that people have regarding their ability to begin and continue movement on selected pathways towards their goals. These two components are known respectively as *pathways thinking* and *agency thinking*' (Snyder *et al.*, 1999: 180-181, original emphasis).

example, how is the component of hope mediated in statutory social work situations where the client may not be seeking help but where contact is imposed?

*Therapeutic Technique* – citing studies which agree that the impact of therapeutic technique on outcomes remains quite modest (accounting for 15% of variation), the authors (McKeown *et al.*, 2001) suggest that a healthy eclecticism in methods of intervention is appropriate. Less attention should be paid to technique specialisation and training. They cite evidence which suggests that personal qualities rather than techniques or training make some therapists more helpful. However, the original work (Hubble *et al.*, 1999) more accurately notes that relationship factors (including personal qualities) play *more of a part* than model/technique factors. Also, the extent to which skills training is beneficial, especially for novice helpers remains unexplored in McKeown *et al.*'s summary.

In concluding on the role of 'the model', Asay and Lambert (1999) note that

Common factors and technical interventions are not mutually exclusive; all therapies use models and techniques. Our hope is that these technically-based interventions will not be assumed to be so well established that their application will become mandatory. "Painting-by-numbers" can produce good results with certain clients, but rigid adherence to manuals and guidelines is not a proven way to the best results. (p. 46)

Prochaska (1999) suggests that beyond the question of what helps in therapy is the question:

... how do people change, period. (p. 227).

## **(II) SOLUTION FOCUSED THERAPY:**

### **SFT's antecedents and emergence**

Solution-Focused Therapy (SFT) was developed by Steve de Shazer, Insoo Kim Berg<sup>84</sup> and their colleagues at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin (de Shazer, 1985; 1988; 91; de Shazer *et al.*, 1986). It was developed for family therapy practice in a clinic setting and the early publications cited above demonstrate this focus. SFT, as initially developed consisted of a formulaic, seven stage practice model for a clinic-based session. The 1986 article (de Shazer *et al.*) outlined the practice model itself. De Shazer's 1985 and 1988 books developed the theory behind the model and his two later books in 1991 and 1994 developed the philosophical foundation of his theories of therapy. SFT, as a practice model, has been developed and promoted primarily as a 'stand-alone' practice model which practitioners can use as long as they work within the fundamental principles of the approach as outlined below.

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<sup>84</sup> That the development of the model was a collaborative exercise centring primarily on de Shazer & Berg but with others contributing a role is evident both from publications and presentations. While this chapter will continue to refer to the model as 'de Shazer's' because all except one of the seminal publications are his, it is in my view more accurate to view de Shazer AND Berg as joint originators of SFT.



De Shazer, in contrast to the ‘change merchants’ referred to by Byng-Hall (1998), has always acknowledged the influence of other theorists and model-builders: in particular Gregory Bateson; Milton Erickson and John Weakland. He also saw his development of the solution-focused model as a *progression* of the MRI approach:

We have chosen a title similar to Weakland, Fisch, Watzlawick and Bodin’s classic paper, “Brief Therapy: Focused Problem Resolution” to emphasize our view that there is a conceptual relationship and a developmental connection between the points of view expressed in the two papers. (de Shazer *et al.*, 1986: 207)

In the early publications, the roots of the SFT approach in strategic therapy were obvious, not only in de Shazer’s conceptualisation of problems, the change process and a treatment model (de Shazer, 1985, 1988; de Shazer *et al.*, 1986) but also in his adoption of many features of the MRI approach, such as *reframing* (defined as changing ‘the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the ‘facts’ of the same situation equally or even better, and thereby changes its whole meaning’, Weakland *et al.*, 1974: 95); the use of *tasks* and the depiction of different *levels of commitment to change*.

He did however, depart from the MRI model in several significant ways:

- (i) The use of compliments as an intervention;
- (ii) The adoption of the therapist-client system as the unit of change;
- (iii) The emphasis on the development of a co-operative relationship; and
- (iv) The shift from task to process.

The way in which these features were incorporated into de Shazer and Berg’s model of therapy will now be outlined.

### **Core principles of Solution Focused Therapy**

De Shazer has stated that the key to his model of brief therapy is

Utilising what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves. (de Shazer *et al.*, 1986: 208)

The main principles underpinning the approach are as follows:

- (i) Problems are seen to develop and to be maintained in the context of human interactions. Individuals are viewed as possessing ‘unique attributes, resources, limits, beliefs, values, experiences and sometimes difficulties, and they continually learn and develop different ways of interacting with each other’ (p. 208). Solutions are seen to lie in ‘changing interactions in the context of the unique constraints of the situation’ (p. 208).
- (ii) The aim of therapy is to ‘help clients do something different, by changing their interactive behaviour and/or their interpretations of behaviour or situations so that a solution (a resolution of their complaint) can be achieved’ (p. 208).

- (iii) Clients are viewed as experts on their own lives. De Shazer subscribes to Erickson's belief that 'individuals have a reservoir of wisdom learned and forgotten but still available'. The task of the practitioner is to facilitate the client in making contact with forgotten or unnoticed wisdom.
- (iv) 'Resistance' is viewed, not as a label to be affixed to particular clients who are deemed to be uncooperative, but as 'the client's way of letting us know how to help them' (p. 209). The key to co-operation in this model is
  - ... to connect the present to the future (ignoring the past, except for past successes) ... point out to the client what we think they are already doing that is useful and/or good for them, and then – once they know we are on their side – we can make suggestions for something new that they might do which is, or at least might be, good for them. (p. 209)
- (v) The meanings attributed to particular behaviours are seen to be of significance, especially in relation to the detrimental effects of labelling. It is proposed that 'any behavior can be seen from a multitude of points of view, and the meaning that the behavior is given depends on the observer's construction or interpretation' (p. 209). Reframing is therefore proposed as a way in which 'new and beneficial meaning(s) can be constructed for at least some aspect of the client's complaint' (p. 209).
- (vi) Goals should be small and achievable, as 'only a small change is necessary' ... [which] can lead to profound and far reaching differences in the behavior of all persons involved' (p. 209). The bigger the goal identified or the bigger the desired change, the more difficult it is to either establish a co-operative relationship or to achieve success.
- (vii) Change in one part of the system leads to changes in the system-as-a-whole, so it is not necessary to insist that family therapy must involve the therapist meeting with the whole family nor for couples therapy to mean that both spouses must be present.
- (viii) Solution-construction does not require a detailed knowledge of the problem pattern:
  - Basically, all the therapist and client need to know is: 'How will we know when the problem is solved?' ... Details of the client's complaints and an explanation of how the trouble is maintained can be useful for the therapist and client for building rapport and for constructing interventions. But for an intervention message to successfully fit, it is not necessary to have detailed descriptions of the complaint. It is not even necessary to construct a rigorous explanation of how the trouble is maintained. (p. 209)

### **Techniques and processes in Solution Focused Therapy**

The solution-focused therapist's goal is to redirect clients from an initial complaint frame' towards a solution frame by focusing their attention on exceptions to the complaint and by using change talk instead of problem talk. This is achieved through the use of a specific style of questioning and particular strategies, now outlined.

### ***Problem-free talk***

The practitioner is encouraged not to go straight into work on the problem when they first meet a client but to engage with the person, rather than the problem. The practitioner starts to 'listen with a constructive ear' (Lipchik, 1988) for the strengths that the client brings and ways they have already developed to deal with adversity.

### ***Exploration of solution patterns***

This takes place by eliciting and amplifying exceptions to the complaint and successful attempts to diminish its effects, and by eliciting and amplifying successful behaviour and thoughts in other areas of life. The focus is on the interactional processes, which either maintain a problem pattern or interrupt it. The search for exceptions (through the use of such questions as: *tell me about the times when it doesn't happen/ when it's less bad/ when you say 'no'*) is seen to be an intervention in itself, as it implicitly lets the client know that there are already times when they are being effective, and therefore reframes them as competent rather than powerless in the face of the problem. It can therefore provide some hope for clients that problems can be solved or alleviated or that they can be competent in the face of problems.

### ***Goal-setting***

is emphasised as crucial, so that both worker and client will know when it is time to terminate contact. Goal-setting also facilitates therapy to be brief and empowering, and facilitates evaluation of progress and outcome. De Shazer later elaborated on the features of well-formed goals (de Shazer, 1991).

### ***Establishing preferred realities***

Through the use of the 'miracle question' (de Shazer *et al.*, 1986), clients are asked to consider what their hypothetical preferred reality would look like:

After you have gone to bed tonight, a miracle happens and the problem that brought you here today is resolved. But you are asleep, so you will not know that the miracle has happened. When you wake up tomorrow morning, what will be different that will tell you? What will you see yourself doing differently? What will you see others doing differently that will tell you that the miracle has happened? (Walsh, 1997: 6)

### ***The small steps of change***

Specific, observable goals are co-constructed by practitioner and client, so that progress will be observable, concrete and seen in terms of achievable steps. While this is seen as a valid exercise in identifying goals, de Shazer also sees it as an intrinsic intervention, in that the

more time spent in the session in ‘change talk’, and the absence of the complaint, the greater the expectation that change is not only possible but inevitable.

### ***Scaling***

is used as a technique to establish goals and to monitor change as it occurs but also to build the belief that change is already occurring. On a scale of 0 to 10, with ten being the worst its ever been and zero being your goal, where would you place yourself now?

Scaling is used as a self-assessment by the client of their closeness to or distance from a goal. It can also be used to encourage a sense of control over a complaint by asking clients to predict where on a scale they might be on a particular day or at a particular time.

### ***Positive feedback (compliments)***

originally in the set clinic format, it was proposed that the formal message delivered at the end of the session should consist of compliments and clues. The compliments were designed to establish a ‘yes set’ (Erickson & Rossi, 1979) of agreement from the client so that he/she/they would be more receptive to the clues or directions put forward. However, positive feedback has since been built into the fabric of the session by many practitioners as an important challenge to view of self as powerless or at fault.

### **Is Solution Focused Therapy a strategic form of therapy?**

It is evident that de Shazer did not produce a completely new theory of change but built on existing concepts and therapeutic wisdom within the family therapy field. de Shazer, both in the classic 1986 article and in subsequent publications, has explicitly conceptualised his SFT model as both a derivative of but different from the MRI model of Brief Strategic Therapy. That SFT is both strategic and complementary to the MRI model was a view expressed by members of the MRI team:

‘At a specific level, I do not think the use of the term ‘strategy’ necessarily implies a contest between therapist and client; indeed I would propose that de Shazer carries on his therapeutic conversations strategically’ (Weakland, 1991: viii).

We focus primarily on attempted solutions that do not work and maintain the problem; de Shazer and his followers, in our view, have the inverse emphasis. The two are complementary. (Weakland & Fisch, 1992: 317)

Some analysts agree that the SFT and MRI models are more similar than different (Shoham *et al.*, 1995; Cade & O’Hanlon, 1993) and that the SFT model is a strategic approach (Weakland, 1991; Shoham *et al.*, 1995) or at least ‘consistent with strategic approaches’ (Gale & Long, 1996: 6):

... the similarities between the MRI and Milwaukee models appear to far outweigh the differences ... both are complaint based; minimalist models that make no explicit assumptions about the nature of healthy or dysfunctional relationships. Both do assume,

however, that small changes ... can lead to further changes ... And when change begins, the brief therapist's main concern is getting out of the way. At a conceptual level, the differences between these two models seem mainly a matter of emphasis – one aims to help clients do less of what does not work while the other identifies and promotes more of what does. (Shoham *et al.*, 1995: 155)

While solution-focused techniques may be used strategically by therapists, I would contend that the differences de Shazer introduced in his model of therapy are sufficient to locate it outside the realm of brief strategic approaches. The main differences include:

- (i) The emphasis given to the concept of 'solution' as opposed to resolution of the problem;
- (ii) The reformulation of the therapist-client relationship as a co-constructivist and collaborative relationship (in contrast to the MRI formulation of a hierarchical relationship with the therapist as 'expert');
- (iii) The focus on process rather than interventions<sup>85</sup> – and the emphasis placed on alternative possibilities and meanings that the therapist offers the client through solution-focused conversations;
- (iv) The SFT view of clients as essentially co-operative and as experts on their own lives<sup>86</sup>;
- (v) The abandonment of the need for a team approach<sup>87</sup>;
- (vi) The rejection of task-setting as a central feature of therapy<sup>88</sup>;
- (vii) The emphasis on meaning;
- (viii) The importance of language.

The specific techniques employed by the therapist using the SFT model, such as the Miracle Question, the identification of exceptions and the use of scaling, are, it can be argued, strategic in nature<sup>89</sup>; and in its initial conceptualisation the SFT model was highly prescriptive in its six-stage formula. However, de Shazer can be said to have fundamentally altered the balance of power in the therapeutic relationship away from a strategic stance, by suggesting that therapists should start from a viewpoint of seeing the client, rather than the therapist, as holding the key to the solution.

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<sup>85</sup> By 1985, de Shazer saw therapeutic change as 'an interactive process involving both client and therapist' (de Shazer, 1985: 65).

<sup>86</sup> De Shazer from his earliest writing was interested in how the most effective relationship could be developed between therapist and client and he began to note the differences in levels of cooperation that were elicited by various strategies such as the use of compliments. In his 1982 model, the contact with families began with what was termed the prelude where the therapist 'is trying to build a non-threatening relationship with the whole family and to learn something about how the whole family sees the world' (de Shazer, 1982).

<sup>87</sup> By 1985 de Shazer viewed the team as less central: 'A team is not necessary for working this way' (de Shazer, 1985: 19).

<sup>88</sup> 'Accepting non-performance as a message about the client's way of doing things allowed us to develop a cooperating relationship with clients which might not include task assignments. This was a shock to us because we had assumed that tasks were almost always necessary to achieve behavioural change' (de Shazer, 1985: 21).

<sup>89</sup> i.e. they fit within a definition of strategic family therapy as being 'specific strategies for addressing family problems' (Piercy & Wetchler, 1996)

The role of the therapist in the SFT model became one of a facilitator who helped the client ‘discover’ forgotten wisdom.

The answer to the question of whether SFT is strategic or not has to be: it depends. And it depends on how SFT is interpreted and practised by individual therapists. In the hands of one practitioner it could be highly strategic, in the hands of another, not at all strategic. It is in the practising of SFT that its true shape emerges, and that is conditional on other qualities related to the practitioner as much as the model itself.

### **The popularity of Solution Focused Therapy**

Given the range of criticisms that family therapy was attracting at the time<sup>90</sup>, the appeal of SFT is obvious: it operates from principles which emphasise the client as a person of resources; it questions the assumption that the therapist knows best and it redefines the role of the therapist as facilitator rather than expert. Strategic therapies had fallen into disrepute primarily because of concerns about the ethics of some techniques, such as paradoxical injunctions (Carr, 1995).

Initially adopted by family therapists, the model began to attract a more general interest from those in the helping professions from the end of the 1980s onwards. It has since been modified for work in various settings outside of clinical environments, with diverse client groups and types of problems, in Europe and Australia, as well as America.

### **Social Constructionist models**

SFT is of a new generation of social constructionist models within the family therapy field. The related ideas of social constructionism, constructivism and post-modernism and their influence on family therapy will now be considered.

*Social constructionism* views ‘ideas, concepts and memories arising from social interchange and mediated through language’ (Hoffman, 1992: 8), and draws primarily on the work of authors such as Gergen, and Foucault.

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<sup>90</sup> Feminist critiques (such as those by Hare-Mustin (1978, 1986) and Pilalis & Anderton (1986), were critical of the blindness to gender difference which system theories encouraged and the low status and lack of attention paid to traditional female roles of caretaking and nurturing.

Consumer studies, such as Howe, 1989, were indicating that clients did not feel understood by therapists on their own terms; sessions were dominated by therapists who set the agenda; clients felt powerless and disliked the videotaping and live supervision. Howe came to the conclusion that systemic family therapy was unable to understand the significance of individual personal experience. It banishes the subjectivity of the user and prevents a genuine dialogue taking place between users and their therapists.

Piercy, Sprenkle, Wetchler *et al.* (1996) have outlined the features of social constructionist models and proposed that four approaches, one of which is SFT, fit this category and are ‘based on the concept that reality is an intersubjective phenomenon, constructed in conversation among people’ (p. 129).

The four main assumptions underpinning the social constructionist models are that:

- (i) *Reality is constructed in conversation*<sup>91</sup>
- (ii) *The systems metaphor for describing families is rejected.*<sup>92</sup>
- (iii) *Therapist expertise holds no more prominence than client expertise.*<sup>93</sup>
- (iv) *Therapy is co-constructed between therapist and client.*<sup>94</sup>

Carr (1995) includes Cecchin (1987) in Italy, McCarthy and Byrne (1988) in Ireland, and Campbell and Draper in the UK (Cambell, Draper & Crutchley, 1991) as central actors in the social-constructionist tradition in family therapy.

### **The influence of constructivism and postmodernism**

The influence of constructivism and postmodernism (as well as the consumer studies and feminist critiques outlined earlier) can be said to have led to the development and privileging of the new range of approaches to therapy.

*Postmodernism* had a broad impact on family therapy in its ability to provide

... a framework within which to address differences and challenge polarities ... while post-modernist ideas seem to reflect well the experiences of fragmentation and saturation that many individuals live in the modern world. (Burck & Daniel, 1990: 29-30)

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<sup>91</sup> What we perceive as ‘real’ is often due to dominant beliefs within ourselves and society as we view the world through the lens of a succession of stories – personal and gendered but also influenced by community, class and culture. As the concept of the ‘self’ is itself socially constructed, therapists do not have any special insights into individual or family life, but are instead participants in constructing a reality with their clients.

<sup>92</sup> The ability of therapists to objectively diagnose families is challenged, and so the systems metaphor which encourages therapists to take an objective stance is also rejected: ‘The concept of systems originally was used as a metaphor for describing families. Over time, therapists began to view families as actually possessing those concepts’ (Wetchler, 1996:131).

<sup>93</sup> Narrative therapists in particular are seen to have highlighted the issue of how psychological knowledge and diagnosis often reproduce dominant cultural values that serve to marginalize the wisdom of those who are viewed as outsiders. By reframing the therapeutic encounter as one to which each participant brings their own expertise, therapy becomes more ethically and morally sound.

By placing therapist knowledge above client knowledge, we not only further objectify and demean our clients, but we also close the door to new and possibly unique ways of viewing and solving client problems’ (Wetchler, 1996: 131-2).

<sup>94</sup> Following on from (iii), a balancing of therapist knowledge with client knowledge leads to therapy becoming a joint venture: ‘The role of the therapist becomes one of opening doors for clients to explore new meanings in their lives. This means engaging them in a slightly different conversation than the ones they usually have around the problem’ (Wetchler, 1996: 132). Through this new conversation, clients develop different ways of viewing their situation, and hence new possible ways of overcoming their difficulties.

Postmodernism is however problematic in according all narratives equal status while undermining any alternative ‘meta-narrative’; and in ignoring context – ‘i.e. our society, which neither confers equal validity and status on all views, nor provides the resources for all views to become established in practice’ (Burck & Daniel, 1995: 30).

*Constructivist* ideas were introduced into the brief strategic field primarily through Watzlawick’s collections (1984; 1990)<sup>95</sup> followed by specific features in family therapy journals in the later 1980s (Efran, Leukens & Leukens, 1988; Leupnitz, 1988)<sup>96</sup>. Constructivism has been defined as

... an epistemological paradigm that has its roots in the writings of the Greek Skeptics ... Constructivists view knowledge as actively constructed by the individual, and although not denying an ontological reality, ‘deny’ the human experience the possibility of acquiring a ‘true representation’ of reality. (Gale & Long, 1996: 13)

Constructivism has been viewed as most useful to family therapists in its scepticism about the concept of truth: ‘When families, or families and professionals, are engaged in battles over ‘truth’, a constructivist frame that incorporates many different truths is invaluable’ (Burck & Daniel, 1995: 26). However the maintenance of a constructivist position leads to a primary focus on the process of *knowing* rather than on what is known. Consequently, taken in isolation, constructivism can be blind to potential ethical and moral issues in relation to what is observed. In addition, the emphasis on subject-centred reality detracts from the process of making connections between issues of oppression or abuses of power within the therapeutic process.

Reder *et al.* (1993) assert that constructivist ideas brought about three important shifts in systemic thinking:

First, emphasis is also given to the functioning of the individual within the group and not exclusively to the collective phenomena of the system. Second, greater attention is paid to the *meaning* that one person has for another and the cognitive, emotional and relationship factors which bind them together. Finally, it is recognised that the presence of an observer changes the context of the observations and therefore modifies the nature of the information gathered. (Reder *et al.*, 1993: 26, original emphasis)

The combination of a social constructionist and constructivist framework has come to be seen as a better balance, encompassing both issues of context and subjective experience. Since the 1990s, this new paradigm offering blends of social constructionism and constructivism has become more influential rather than less (McNamee & Gergen, 1992; Carr, 1995). The effect it has had on brief therapists, some of whom started off using a pure strategic MRI model, is described thus:

We are now less certain, less audaciously tactical, less wedded to over-simplistic models, and far less impressed with our own cleverness. We have become more concerned with the resourcefulness of our clients and with avoiding approaches that disempower, either

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<sup>95</sup> ‘The Inverted Reality’ (Watzlawick, 1984) drew together contributions from a number of constructivist philosophers, of whom the radical constructivist, Von Glaserfeld, appears to have had most impact on both the MRI and the Milwaukee team (de Shazer, 1988, 1991).

<sup>96</sup> They were introduced into the wider family therapy field through the work of the Milan associates, especially Boscolo and Cecchin (Boscolo *et al.*, 1987), informed by the constructivist school of Maturana & Varela (1987)



overtly or covertly. We have become more concerned with the development of a cooperative approach. (Cade & O'Hanlon, 1993: xii)

### **Solution Focused Therapy and social constructionism**

SFT and the social construction paradigm appear to fit each other, with the exception of specific *strategies* used by the therapist. Although the metaphor of a conversation may now be used to denote the therapeutic encounter, to signal the changes towards a more equal relationship between client and therapist and to indicate that both have contributions to make, there is a limit to how far the metaphor can be taken if the therapist is also to fulfil his or her professional and ethical obligation to offer some expertise in how problems may be solved or solutions constructed. Not only in SFT but in its closest relative within the social construction field: narrative therapy, specific tools *are* used by the therapist to help clients make changes – such as the Miracle Question, scaling and exception-finding questions; externalising the problem and identifying ‘unique outcomes’.

In accepting that therapists use influence to help people to change and use these ‘tools’ to help them to do so, brief therapists implicitly restrict the extent to which the metaphor of ‘conversation’ can be used to depict the therapeutic encounter. O'Hanlon acknowledges that in therapy it is impossible not to influence, and that therapists need to find a way to be open to influence by clients, and that this can best be done by listening to clients: ‘You can validate their experience and let them teach you what works and doesn't work for them’ (O'Hanlon, 1991: 109).

The issue of how influence is used in work with vulnerable people is as much a preoccupation for social workers as it is for therapists. The development of anti-oppressive and anti-discriminatory frameworks for practice (Dominelli, 1988; Thompson, 1993; 1999) evolved from a concern about how workers sometimes use their power in an oppressive manner.

### **Solution Focused Therapy: A moving target**

SFT is acknowledged by many as still in a state of evolution, which means that: ‘Any description of solution-focused therapy by outsiders will be, at best, a partial snapshot of a moving target’ (Shoham *et al.*, 1995: 151-2). This theme is not only accepted by de Shazer but elaborated upon:

We believe that it is useful to think about solution-focused therapy as a rumor. It is a series of stories that circulate within and through therapist communities. The stories are versions of the solution-focused rumor ... Our goal is *not* to offer the final, definitive and only credible story about solution-focused therapy. We recognize that rumors belong to whole communities. No particular story-teller ‘owns’ a rumor. (Miller & de Shazer, 1998)

That SFT has continued to evolve is evident from the post-1986 publications of de Shazer (1988; 1991; 1994), Berg (1991; 1994) and others who have adapted or developed it for various settings. de Shazer (1991; 1994) in particular developed his ‘interactional’ constructivism further and since appears to be more focused on Wittgensteinian concepts of the importance of language as a defining factor in the creation of reality, thus his definition of SFT in 1991 was that of:

A negotiated, consensual and cooperative endeavour in which the solution-focused therapist and client jointly produce various language games focused on a) exceptions, b) goals and c) solutions. (de Shazer, 1991: 74)

A more fitting description for the ‘moving target’ which is SFT may therefore be a form of therapy that is underpinned by a number of principles developed from existing wisdom within the family therapy field, which utilises some simple strategic interventions, but does so within a social constructionist perspective and with a strong dose of hopefulness at its core. A recent definition sums up this combination of ingredients: ‘Solution-focused brief therapy is a strategy for encouraging clients to persuade themselves that their lives are not as troubled as they assume’ (Miller, 1997: 18).

As the model remains dynamic and is being interpreted and applied in diverse ways, it is probably more accurate to refer to the ‘family’ of Solution Focused approaches, which are themselves increasingly seen to belong to a larger grouping (or ‘community’) of collaborative, language-based approaches. These are part of a new generation of approaches to change-work based on the epistemology of social constructionism and premised on the philosophical position that the therapist or worker is not an omniscient expert but a facilitator to the client seeking change. de Shazer’s model of SFT provides some technological (know-how) tools with which this aspiration can be put into practice.

While de Shazer launched his model in 1986 as a complete ‘prescription’ for therapy, this status is debatable and the modifications that have been made since then both by the originators and those who have applied it in various settings<sup>97</sup> suggest that it is used as a set of principles and techniques which can be applied in a versatile and flexible manner to a range of problems and client groups by a range of professions.

### **(III) EVALUATION OF SOLUTION FOCUSED THERAPY**

#### **Research studies**

There have been several different types of research studies into SFT:

- (a) Outcome studies conducted by researchers in clinics where the approach has been used; and
- (b) Independently conducted empirical studies using externally validated measures.

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<sup>97</sup> Examples include: residential child care in Australia (Durrant, 1993), groupwork with paediatric nurses in the UK (Goldberg & Szyndler, 1994), social work in child psychiatry in Ireland and the UK (Wheeler, 1995; Sharry, 1996), mature social work students in the USA (Baker & Steiner, 1995) adolescent and adult substance abusers (Berg & Gallagher, 1991; Berg & Miller, 1992; 1995), Home Based Services for children and families (Berg, 1994), child psychiatry in Finland (Furman & Ahola, 1993), community care social work in Ireland (Walsh, 1995; 1997), generic social work practice in Finland and the USA (Sundman, 1997; Maple, 1998), counselling practice in the USA (Littrell, 1998); fostering social work (Houston, 2000) and groupwork (Sharry, 2001) in Ireland, child protection in Australia (Turnell & Andrews, 1999), the USA (Berg & Kelly, 2000; de Jong & Berg, 2001) and social work practice teaching in the UK (Bucknell, 2000).

### ***Outcome studies***

At the Milwaukee clinic, outcome studies have been carried out since the development of SFT. They followed the MRI formula for outcome assessment, and consisted primarily of client feedback: the follow-up of clients, some months after treatment ended, to ascertain levels of satisfaction with the outcomes of therapy. de Shazer defends this approach, maintaining that since therapy usually starts with a client coming with a complaint, the only way of judging effectiveness is to ask the client if the complaint is still there. It also fits more comfortably with the constructivist paradigm to use the client's subjective experience to ascertain whether the therapy worked, as opposed to an externally devised and assessed instrument of measure.

Reported research results from the USA (de Shazer *et al.*, 1986; Kiser, 1988; 1990) and the UK (George *et al.*, 1990) indicate that this approach enjoys a similar, but not superior, rate of success to other established brief therapy methods (Budman & Gurman, 1988). Between 66% and 72% of respondents met their goals for treatment or made considerable progress towards them, in an average number of sessions ranging from 4-6. While (direct comparisons) with the Budman and Gurman assessment of brief therapies are problematic, due to the wide range of approaches contained under the 'Brief Therapy' label, it indicates that this way of working has established an effectiveness at least similar to that of other short-term approaches.

Given that the Milwaukee outcome studies did not differentiate between therapists, or attempt to separate out impact of therapist qualities from client qualities from model qualities, it becomes more difficult in the light of the more recent studies on 'common factors' to justify a claim that SFT has any particular unique qualities on the basis of these research studies alone.

One study (Wheeler, 1995) on the use of the approach in child psychiatric social work in the UK used a different measurement, that of case outcomes in relation to the use of the method (i.e. were cases closed, referred on, or clients stop attending). An interesting result in this small survey, was a significant difference in referral-on rates between cases seen not using the approach, and those seen when using the approach. When using SFT, Wheeler's referral-on rate reduced to 11% from 31% in a total sample of 73 cases. This suggests the approach may impact *on the practitioner's* level of belief in client's competence.

### ***Independently conducted empirical studies***

The second type of study is of a more traditional, scientific nature. In addition to individual empirical studies, the *Journal of Family Therapy* in May 1997 published five empirical studies of SFT. These studies were necessary in the view of editor John Carpenter for three different reasons: firstly because Solution Focused Therapy was the 'flavour of the month'; secondly because it was

presented as deceptively simple<sup>98</sup> and thirdly because there was a paucity of studies that formally evaluated the model.

- (i) *McDonald's* (1997) follow-up study of clients of an adult psychiatric clinic in Scotland, who received a form of SFT was based on reports from 36 of the 39 clients and from their GP's. The results indicated a 'good outcome rate' of 64%, approximately in line with a previous evaluation by the same author, and with estimates of the overall efficacy of other psychotherapies;
- (ii) *Zimmerman et al.* (1997) researched the use of the approach in couples work in the USA., where solution-focused couples therapy was combined with a 'psycho-educational component'.<sup>99</sup> Using a comparison group, their pre- and post-test scores indicated that 'treatment couples experienced some benefit from being involved in the solution-focused couple therapy groups', with significant changes in all four subscales used as a measurement instrument. They suggest: 'perhaps the positive focus and emphasis on strengths, skill-building and general 'fellowship' of the couples groups contributed to this improvement' (*Zimmerman et al.*, 1997: 139);
- (iii) *Eakes et al.* (1997) conducted a pilot study of brief therapy with families, where one member had a diagnosis of schizophrenia, and was receiving medication. Using a control group and experimental group design, they pre- and post-tested the ten participant families using an instrument which measured family roles and relationships. Their form of therapy combined solution-focused work with a reflecting team approach. They found significant differences between the groups in relation to expressiveness, active-recreational orientation, moral-religious emphasis and family incongruence. The first two of these scales showed positive increases after family centred SFT, indicating a positive change towards more expressiveness and participation in social and recreational activities by the family members.
- (iv) *Beyerbach and Carranza's* (1997) study of dropout from solution-focused therapy in a private clinic in Spain compared relational communication of 16 sessions prior to dropout from therapy with relational communication of 16 sessions after which clients continued in therapy. They used two different coding schemes. Their findings indicate that dropouts are not a homogeneous group, but more importantly their study:

... provide some empirical evidence to support the idea that therapists should promote supportive, harmonious and non-conflictual therapeutic conversations. A viable relationship is built, they suggest, on a close

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<sup>98</sup> 'A simple formula incorporating the 'Miracle Question', the use of rating scales, giving compliments and homework tasks (which seems to imply that anyone can do it), one suspects that there is more to it than appears at first sight' (*Carpenter*, 1997: 117).

<sup>99</sup> The psycho-educational component consisted of a portion of the group session being devoted to some teaching on 'myths that lead to relationship drain and guidelines for goal-setting ... focusing on what works ... pattern recognition and interruption strategies... evaluating pattern interruption failures ... and planning for backsliding' (*Zimmerman et al.*, 1997).

*following* of the client's lead rather than on *strategizing*. (Carpenter, 1997: 120)

- (v) *Sundman's* study of the introduction of solution-focused ideas into a social work agency in Finland, involved an experimental group of social workers who received 'minimal' training in the approach (which was a combination of the SFT and MRI models); a well-matched comparison group of social workers (a total of 25) and some 382 of their clients. Outcomes were measured in a variety of ways: initial questionnaires about their work with the selected clients; tape-recordings of randomly chosen meetings; and follow-up questionnaires completed jointly by worker and client. A total of 52% of the questionnaires were completed. While there were no significant differences between the experimental and comparison groups in terms of goal achievement, the study indicated that clients who received the solution-focused intervention 'were more satisfied, more goal focused and more engaged in joint problem-solving with their social workers' (Carpenter, 1997: 119).

*Lee* (1997) in a rigorous<sup>100</sup> one group post-test design study evaluated the use of SFT in a children's mental health centre in Toronto, and found a 64.9% success<sup>101</sup> rate for an average of 5.5 therapy sessions over a range of 3.9 months. This study confirmed the success rates of SFT as roughly equivalent to those of other brief therapies (but less than that claimed by de Shazer of between 72-80%). *Lee* suggests that this may in part be due to the differing experience levels of therapists at the two centres and that

... the good success rate reported by clients in this study provides initial evidence that solution-focused therapy can be practiced by therapists with varying levels of experience and still generate a satisfactory outcome for the clients. (p. 13)

That no differences were found when analysed for other variables suggests that the approach

... could work equally effectively with boys and girls of different age groups who live in diverse family constellations and have parents from different socio-economic strata. Differences in major demographic characteristics of clients present no barrier to the applicability of the approach. (p. 13)

She also had important findings in relation to the process of helping: 'being supported and validated' was the most frequently mentioned helpful element (echoing *McKeown et al.*'s work) and she surmised that 'Rigid adherence to techniques can be perceived as the therapist's being inflexible, rigid, too positive, artificial and/or insensitive – all negatively related to goal attainment.' (p. 14). Thus, forcing the approach on clients who are not responding is counter-productive.

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<sup>100</sup> All families who received treatment from the solution-focused team within a three year period (1990-1993) were included, and were contacted by an independent interviewer six months after their contact with the clinic had ended. 59 families agreed to participate. A 14 item questionnaire based on that used by the BFTC in Milwaukee was utilised and a sample of coding was cross-checked by two independent raters.

<sup>101</sup> 'Success' being defined as either goals being met or partly met.

Other findings<sup>102</sup> suggest that the nature of the presenting problem may have an important influence on goal attainment, with school-related issues and children's emotional regulation most positively connected with goal attainment. Lee suggests that these goals may be particularly amenable to change through small, concrete, behavioural steps. She poses the question of how clients who perceive their problems in more complex, global terms (such as family relationship problems) might be helped to think more in terms of concrete, small and observable behaviours.

### **Implications of research studies<sup>103</sup>**

Firstly, in none of the studies did participants use the SFT model in its complete form – rather they took aspects of it and adapted it to the specific context. The most commonly used aspects were: goal-setting; positive feedback; exception-finding; scaling; and in only one case (McDonald) the Miracle Question. Lee (1997) describes the use of specific types of questions<sup>104</sup> as the central component of SFT.

Secondly, both McDonald and Lee looked specifically at socio-economic status as a variable, and found no significant variation in outcome for different social and occupational groups. This is of importance as it differs from published outcome studies of other 'talking treatments', all of which are said to show greater benefit for those of higher socio-economic status<sup>105</sup>. This raises the possibility that solution focused brief therapy is potentially of more use with people of different socio-economic groups (and in Lee's study from a range of ages, educational backgrounds, and family types) than other forms of therapy and consequently of more relevance to social work. For one rather sceptical critic it indicates: 'The potential benefits of SFBT for poor people with significant problems' (Carpenter, 1997: 118).

Thirdly, in Sundman's Finnish study, although there were no differences in outcome, there *were* significant differences in the client's reported experience of social work contact between those who received a solution-focused contact and those who did not. The workers involved received minimal training in what the researcher termed solution-focused '*ideas*' which emphasised goals, exceptions

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<sup>102</sup> There were suggestions that presenting problems had some influence on outcome – 'family relationship problems' associated with negative goal attainment; 'children's emotional regulation problems' associated with positive goal attainment.

<sup>103</sup> This summary includes only the major studies published in peer-reviewed journals. It is accepted that there has been a range of smaller studies since and a range of publications describing its use but a close perusal of an index of studies available on the internet from the European Brief Therapy Association has not identified any other significant evaluation studies.

<sup>104</sup> Exception, Outcome, Coping, Relationship and Scaling Questions.

<sup>105</sup> McKeown *et al.* (2001) 'Numerous studies suggest that lower socio-economic groups are less likely to use therapy and more likely to drop out of therapy, possibly because the client – and the therapist – have low expectations of a successful outcome' (p. 25).

and positive feedback<sup>106</sup>. The SFT clients were more satisfied, more goal focused and more engaged in joint problem-solving with their social workers, which indicated that a collaborative relationship had been developed. Nor were these clients at the ‘soft’ end of the problem spectrum – being either child welfare “cases” or single men with serious addiction, mental health and housing issues. What was *not* examined was what effect the training and use of SFT had on the perceptions or attitudes of the workers.

Fourthly, although an inferred result rather than a directly stated one, Wheeler’s drop in referral-on rates when using SFT suggests that using the approach may alter *practitioner’s* perception of the coping abilities of their clients and their hopefulness regarding the possibilities of sustained change.

Overall, the focus of these studies was on outcomes for clients receiving SFT interventions, and they confirm that from this perspective, SFT can be useful at times. But it is not the *only* perspective, and the voice of the practitioner using the approach is missing: what effect does using SFT have on workers? Does this vary, and if so why? Is it dependent on the worker, the client, the context or a combination of all three? These are some of the issues which my study will explore.

### **Critiques of solution focused and brief methods**

Some authors have taken issue with brief methods of treatment, others with cognitive approaches and others with SFT itself. The more general critiques will be explored first and followed by those specifically concerned with SFT.

#### *General concerns*

Some influential British commentators have deplored the rise of brief, focused methods of intervention. Howe (1996) has criticised the rise of a radical liberal perspective where

‘actions are judged more by their results and consequences’ [and] It is the client’s performance which matters and not what causes it ... Clients arrive, in effect, without a history; their past is no longer of interest. It is their present and future performance which matters’ (pp. 88-9).

Howe believes that with this development, little attention is paid to the construction and understanding of the client’s narrative:

In task-focused and contract-oriented practices, immediate realities are negotiated, and definitions of what is and what is to be are agreed. Clients are not located and understood within the context of an ordered narrative; their story is not framed within a theoretical perspective whose principles govern what is said and done. Each episode of social-work intervention is discrete and unrelated to previous episodes. Work is short-term, time-limited and ‘brief’ ... There is no accumulated wisdom because there are no psychological or sociological theoretical frameworks in which to order and store it. Each new encounter simply triggers a fresh set of transactions, negotiations and agreements. (pp. 90-1)

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<sup>106</sup> Although the training and supervision did seem to include some skills development as well.

Howe maintains that this preoccupation with ‘surface’ rather than ‘depth’ prevents social workers from understanding and appreciating the non-rational and distressed behaviours of people under stress in modern society and that this inhibits their ability to respond appropriately:

If the social worker is to make sense of what is going on and respond both sensitively and flexibly, she or he will need more than a repertoire of surface competencies. Social workers will need a theoretical outlook which allows them to make sense of contingent events and non-rational behaviour. They will need knowledge and skills to give them the ability to respond independently and on-the-spot to difficult situations and troubled people. (p. 96)

Another influential British social work academic has also raised concerns about the appropriateness of short-term targeted interventions with particular problems such as neglect of children:

A ... problematic element in practice, which mirrors wider changes in society, may be described as more purposeful, ‘targeted’ modes of intervention, designed to avoid long-term dependency. (Stevenson, 1998a: 111)

Stevenson’s concern is for the outcomes for severely neglected children in the UK. Her earlier research (Stevenson, 1998b) had indicated that neglected children were not receiving an adequate assessment or social work service and she felt this was *partly* attributable to the increased emphasis on focused interventions. Some of her concerns mirror those of Howe in regard to the lack of attention paid to meaning and causal theories:

The need to find meaning in the behaviour of neglectful parents is a prerequisite for effective work with them ... Why cannot a parent control or protect their children? Why do some parents live in utter squalor and discomfort? (p. 113)

While not dismissing totally the case for short-term interventions, she maintains that for particular problems, they may not be appropriate:

A desire to move away from earlier practices of unfocused ‘supportive work’, of cups of tea and chats, was entirely laudable. But in this type of work [with severely neglected children] it is possible, and often necessary, to have specific plans for intervention within a framework of long-term work. In reality, the work is often long-term. (p. 114)

Clearly, some clients and client groups will need continued help over time but whether that rules out the possibility of short term focused help at some points is the issue.

Taken in isolation, the original de Shazer *et al.* article (1986) which launched SFT might yield the impression that SFT is a totally strategic approach, using the concept of ‘solutions’ to trick clients into thinking differently about their problems<sup>107</sup>, and narrowly focused on outcomes as Howe worries.

If this were how it was practised, it would raise questions about ethical practice. However, as outlined earlier, many SFT practitioners emphasise the quality of the relationship forged between

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<sup>107</sup> Howe has elsewhere contended that ‘the most insidious exercise of power is to prevent people from having grievances by shaping their perceptions, cognitions and preferences’ (Howe, 1986: 112), although whether instilling hope and encouragement for demoralised and oppressed clients falls into this category warrants a thesis in itself.



worker and client, and focus on process. Lipchik (1994) notes that the most obvious clinical error of all when using SFT is to

... focus on the technique and neglect the actual flesh-and-blood client sitting with them  
... in general, the choice of techniques should be driven by how a particular technique will serve and fit the client, not the therapist. (pp. 37-8)

Research studies cited suggest that SFT is not used in a formulaic manner but has been thoughtfully combined with other approaches, and sometimes ‘re-invented’<sup>108</sup> to meet the needs of specific clients or client groups.

Interestingly, another reading of SFT has deemed it to fit within a humanistic perspective (Payne, 1997). Payne suggests that those who argue from a humanistic perspective ‘are reasserting the importance of belief in the capacity of humanity to improve itself’ (p. 177) and he notes that solution-focused ideas are particularly influential.

These differing interpretations of SFT illustrate and reflect both the roots of SFT in strategic family therapy and its development along social constructionist lines. They suggest that there is a range of ways in which SFT may be perceived.

The issues raised by these critiques can be posed in the form of questions regarding practitioners’ use of SFT:

- Do practitioners use it to the exclusion of other theories and models?
- Is adoption of the approach wholesale or selective?
- Do they use it primarily in a time-limited and performance-focused way?
- Are clients’ narratives ignored?
- Do workers try and use it to persuade clients that their troubles do not exist?

#### *Political concerns*

Objections to brief models of therapy have also been made on political grounds – based on the legitimate fear that policy-makers and budget holders ultimately restrict choice and therapists’ professional freedom by imposing restrictions on lengths and types of treatment. The introduction of ‘Managed Care’ in the USA, and the curtailment on length of treatment paid for by private insurance companies in Ireland and the UK, have illustrated that these fears are justified. The issue centres not on dismissing the real benefits which brief methods can offer but on promoting a deeper analysis of the complex nature of many problems which acknowledges

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<sup>108</sup> The concept of ‘re-invention’ is one which will be examined in greater detail in later chapters as an component from Innovation Diffusion theory (Rogers, 1995).

that active change-work is not always possible or appropriate. Where it is, other activities might be needed to move people towards action contemplation.<sup>109</sup>

#### *'Grand claims' concerns*

Concern has been expressed by some North American social work academics about the indiscriminate acceptance of the SFT model by some social workers and social agencies 'in spite of the dearth of empirical evidence for its claims to provide clients with more rapid and more enduring change than other treatment models' (Stalker *et al.*, 1999: 468). These objections have been echoed in the addictions field: concern has been expressed about SFT promoters (Miller & Berg, 1995) advocating 'The Miracle Method' as a radically new approach to problem drinking. This claim is excessive given that

... not a single scientific evaluation has yet been published to support the 'solution-focused' counselling method that it described ... [and] Desperate and vulnerable people deserve, and have a right to expect, a higher standard of professional responsibility and accountability. (Miller, 2000: 1,765)<sup>110</sup>

Stalker's and Miller's objections to the approach stem from the exaggerated claims that some proponents of SFT have made, especially in 'selling' the approach to both practitioners and clients. Clearly there are issues involved in exaggerated claims: claiming *anything* as a 'Miracle Method' in the treatment of often intractable addiction problems is unethical. As outlined above, the main research studies conducted appear to show that it has a comparable rate of 'success' to other brief models. None of the studies reviewed for this thesis claimed that it was superior, but the effects of using the approach appear to be quite interesting although subtle. That both critiques emanate from North America may reflect the lucrative and competitive nature of the therapy business there, but as Edwards notes,

People in that sort of situation are, however, immensely vulnerable to the blandishments which may be offered by any treatment approach which is marketed with large claims for efficacy and carries a public relations message which connives with expectations of a magic cure. (Edwards, 2000: 1,749)

#### *'Insensitivity' concerns*

Fook has critiqued the growing development of strengths perspectives which she maintains do not take account of the differing realities, vulnerabilities and challenges that individuals experience over their lifetimes:

'Progressive' models of practice assume an ideal of 'strength' towards which the healthy personality works. Such views, however, do not take into account the changing contexts and historical times which all people experience in the course of

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<sup>109</sup> One increasingly popular example which does just that is Miller's (1989) Motivational Interviewing'.

<sup>110</sup> By Oct. 2001, William Miller's criticism would still be valid. From the latest listings of SFT evaluation studies available from the European Brief Therapy Association's web pages, only 2 studies involving problem drinking are cited, one by Insoo Kim Berg which is only cited as evidence in 'The Miracle Method' book, another by Isabert & Vuysse which is described as 'in preparation'.

a lifetime. In this sense, practice models may be far out of touch with the experiences of service users. (Fook, 2000).

The point Fook appears to be making is that people in vulnerable states at particular points in their lives may not be able to envisage themselves as people with the ability to change. As noted earlier in this chapter, ‘coping’ questions are a central part of SFT, developed to use where hope is missing<sup>111</sup>. Fook may also be making the valid point that change-work is not always appropriate, and that sometimes, helpers help by just listening and bearing witness to a client’s troubles.

### *Feminist concerns*

Dermer, Hemesath and Russell’s (1998) feminist critique of SFT starts from the premise that such critiques can ‘identify gender and power imbalances and biases unintentionally perpetuated through therapy’ (p. 240). Drawing on one of de Shazer’s publications (1985) and comparing SFT to Leupnitz’s (1988) model of feminist therapy, they conclude that SFT fails in certain respects but in others is congruent with feminist ideals. Their principal objections centre on

- (a) the concentration on behaviour change to the near exclusion of insight or explanation: a ‘tendency to overlook larger contexts within which families operate’ (p. 241);
- (b)(the) adherence to notions of circularity leading to a rejection of the concept of blame as ever helpful: ‘From this perspective, getting bogged down in questions of blame keeps people stuck in their problems instead of promoting change’ (p. 242). Making a distinction between ‘nonproductive blame’ and ‘other-angered blame’<sup>112</sup>, Dermer *et al.* assert that both feminism and solution-focused perspectives ‘recognize that nonproductive blaming is not therapeutic, and both perspectives highlight responsibility ... [they] agree on matters of personal responsibility but differ on the subject of blame’ (p. 242);
- (c) the relativist tendency inherent in SFT<sup>113</sup> leads to a lack of attention to pressures inherent in unequal power relations; a consequent failure to engage in any thorough pluralist analysis (‘which examines the possibility that what is good for the family may not be what is good for an individual’, p. 243); and

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<sup>111</sup> ‘Like all workers, we encounter clients who are feeling hopeless and seem able to talk only about how horrible their present is and how bleak their future looks. Sometimes these clients are experiencing an acute crisis that gives rise to their hopelessness, and at other times the hopelessness represents a persistent pattern of self-expression and relating to others. *In both cases, coping questions can be helpful in uncovering client strengths.*’ (de Jong & Miller, 1995: 733, my emphasis).

<sup>112</sup> The former obscures each individual’s responsibility and the latter identifies limitations placed on subordinate groups by dominant groups.

<sup>113</sup> By placing a great emphasis on client-determined goals, SFT can be charged with taking a position of absolute relativism leading to unethical practice if no stand is taken by the therapist to challenge damaging or dangerous goals.

(d) the ‘neutral’ therapist as advocated in SFT is more likely to unwittingly collude with existing oppressions<sup>114</sup>.

Where SFT and feminist therapy converge is on the position of the therapist and the value base of the approach. The feminist therapist aims to adopt a position which is enabling and which values purposive self-disclosure as a starting point for emphasising difference, and in this respect is roughly similar to solution-focused therapists. SFT is seen to be most congruent with feminist therapy in relation to the role of the therapist and the nature of the therapeutic relationship; both advocate a collaborative relationship, clear therapeutic goals and attention to the power of language. Dermer *et al.* conclude that while SFT uses methods congruent with feminist therapy, it falls short of feminist principles in its lack of attention to inequality and gender relations. SFT is, in their analysis, guilty of sins of *omission* rather than sins of commission.

Dermer *et al.* are correct in their identification of the lack of any structural or gendered analysis within the original SFT theory. This weakness has been acknowledged by women therapists such as Lipchik (1991),<sup>115</sup> Lethem (1994) and Dolan (1991) who have developed their SFT practices to include a more explicit ethical stance when working with victims of domestic violence and sexual abuse.

A key issue in the feminist critique is how political the therapy process should be. For Dermer *et al.*, as feminist scholars, therapy is viewed as a *political* process, and ‘As such, therapists should preserve their own beliefs while appreciating other positions’ (p. 243). Neutrality is seen as an unacceptable position because ‘failure to espouse one’s own beliefs and values may unintentionally reinforce the status quo. Clients may interpret neutrality as agreement with their political and personal views’ (p. 243).

For de Shazer on the other hand, it is unacceptable for the therapist to promote their own values and beliefs in sessions. He distinguishes between the goals of therapy and therapists’ personal orientations.

Therapists ask questions and make suggestions that are designed to help clients improve their lives ... Therapists who fail at this job fail at therapy, no matter what else they may accomplish in the process ... The other set of questions ... involve solution-focused and other therapists’ orientation to developments in other aspects of society ... Therapists often use [certain] questions and answers to define therapy as a **cause**, and to assign different kinds of therapy to different causes. Stories about these issues are mostly told by therapists to other therapists. Thus, clients’ concerns and influence on the therapy process

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<sup>114</sup> Citing Berg (1992), Dermer *et al.* are particularly critical of solution-focused therapists’ espousal of a neutral stance in domestic violence, which while condemning the violence itself will make no move to advocate a woman leaving a violent partner, or to side with a woman against a violent partner.

<sup>115</sup> Lipchik (1991) defends the use of SFT in ‘spouse abuse’, that her priority is always the prevention of further violence, that therapy stops if the commitment to ending violence is breached and that while she focuses on solutions that are ethical and consistent with clients’ own values, one of her own beliefs is that ‘sociopolitical issues must be addressed in some way in all cases’ (p. 63).

are often minimized in these stories. Understandably, most clients have little interest in them. Why should clients care about the intellectual, political and other causes with which their therapists are identified? Clients have their own problems. (Miller & de Shazer, 1998: 367)

The development of more gender sensitive forms of SFT, such as those proposed by Lethem and Dolan suggest that it is possible to combine the broad concepts of solution-focused therapy with anti-oppressive practice. Yet the case remains that unless the practitioner comes to SFT with an already developed sensitivity to gender and power issues, he or she will not find a framework for anti-oppressive practice in current SFT theory.

Given the importance of social work as a moral enterprise, with its emphasis on the effects of oppression and its commitment to a role in promoting social justice and advocating on behalf of oppressed groups and individuals, the forms of SFT which appear most consonant with social work are those which incorporate an anti-oppressive position such as the work of Lethem (1994) and Dolan (1991).

#### **(IV) SOLUTION FOCUSED THERAPY AND SOCIAL WORK**

##### **Social constructionism in the helping professions**

A review of counselling, social work and child care journals over recent years indicates that the philosophy of social constructionism has permeated into other helping professions besides family therapy (Saleebey, 1994, Pozatek, 1994; Pardeck *et al.*, 1994; Parton & O'Byrne, 2001).

The SFT emphasis on developing a collaborative stance, on taking context into account; and on the importance of language and meaning, are all now popular concepts in the fields of counselling, social work and child care, and are seen by some as being encapsulated in a new philosophy:

In recent years a new resource-oriented philosophy of approaching human problems has emerged in the field of psychotherapy. This philosophy builds upon openness and cooperation focusing on what is positive – on strengths, progress, and solutions. The application of this philosophy is not restricted to psychotherapy; it appears to be relevant across the entire spectrum of the helping services. (Furman & Ahola, 1992: 162)

In the case of social work, the 'new' interest in strengths and resources is a reawakening of a core aspect of the social work ethos. Saleebey (1997) notes that 'From its inception as a profession, the field has been exhorted to respect and energize client capacities' (p. 15). In developing 'The Strengths Perspective in Social Work' (1992, 1997), Saleebey has become one of the primary theorists for the resource-based approach.

### **SFT and Social Work practice models: Differences and similarities**

SFT can be seen, in its philosophy and techniques, to have features in common with several different approaches commonly used in social work practice, specifically task-centred<sup>116</sup>; cognitive-behavioural and humanistic models.

Task-centred casework shares with SFT a concentration on achievable goals, a focus on short-term work and an active role on the part of the worker. With cognitive-behavioural therapy, SFT shares an emphasis on goal-setting, the importance of both perception and behaviour in maintaining problems, and the use of scaling questions.

The philosophy of SFT is primarily humanistic with the emphasis on the client's experience of the encounter and in the belief in the self-actualising or resource-based nature of human beings.

SFT shares with cognitive-behavioural therapy an emphasis on establishing small goals, use of scaling and self-assessment and the importance placed on the client's view of the problem and the need for the worker to reshape problematic negative thinking. It shares with the task-centred model an emphasis on the client's definition and prioritising of the problem(s), the establishment of small tasks, and the importance of short-term work focused on goal achievement. Differences exist in relation to the emphasis placed on open-ended work in the humanistic tradition, in the position of the worker as trainer and educator in the cognitive-behavioural approaches, and in the attention paid to indirect as well as direct work on the part of the task-centred worker.

Of these three approaches however, only the task-centred approach is a practice model developed specifically for social work practice. Cognitive-behavioural and humanistic 'approaches' are broader categories containing within them many different practice models not exclusively for social work but also for psychology, psychiatry and therapy (Payne, 1997).

The more recently introduced strengths perspective (Saleebey, 1992; 1997) is the approach with the tightest fit philosophically with SFT. Although the roots of the strengths perspective are seen to 'reach deep into the history of social work' (de Jong & Miller, 1995: 729), it was not until the late 1980s that the philosophy was finally articulated as a specific approach to social work practice. The approach is based on 5 core assumptions:

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<sup>116</sup> Task-centred casework was a development from Reid and Shyne's (1969) experiment in brief and extended casework which exemplified both the advantages of short-term work and a more active approach by the practitioner: 'in short-term treatment social workers used more techniques directed towards promoting change, less passive exploration and more active intervention ... The clients preferred the active style and expressed more positive feelings about the social workers. Reid and Shyne suggested that the immediacy, sharpness and urgency of short-term work lead, in comparison with long-term help, to less improvisation and drift and more selectivity in treatment objectives, more focus on realisable goals and less concentration on unalterable underlying causes. Furthermore, the 'set' was different from the very beginning: clients accepted that change would occur within a brief period' (Goldberg, Gibbons & Sinclair, 1985: 4).

- (i) that all persons and environments possess strengths that can be mobilised to improve the quality of clients' lives;
- (ii) that client motivation is best mobilised by a consistent emphasis on strengths as the client defines these;
- (iii) that a co-operative exploration between client and worker is the best process for discovering strengths;
- (iv) that focusing on strengths diverts the practitioner's attention away from negative stereotyping which can lead to a blaming of the victim; and
- (v) that all environments – even the most bleak – contain resources (de Jong and Miller, 1995).

Solution-focused questions are proposed as specific tools which can be used to develop the strengths philosophy on a micro-practice level – with individuals, couples and families. The authors concluded that

It is hard to imagine a tighter fit between philosophy and practice than that between the strengths perspective and solution-focused interviewing questions. (de Jong & Miller, 1995: 735)

### **Constructive Social Work**

Parton and O'Byrne (2000) outline a social constructionist framework for social work practice which incorporates both solution focused and narrative concepts and techniques. Parton and O'Byrne propose a *constructive social work* approach based on the view that social work is not a technical-rational activity but a *practical-moral* one, best characterised as an art rather than a science. Their constructive approach:

... emphasises process, plurality of both knowledge and voice, possibility and the relational quality of knowledge ... The social worker does not presume to know what is best and what to do. An ability to work with ambiguity and uncertainty both in terms of process and outcomes is key. (p. 184)

Parton and O'Byrne emphasise the extent to which constructionist approaches fit ethically with social work:

The hallmark of ethical practice is that we are reflexive and embark on a process which is mindful, respectful and aims to empower. The ethic of responsibility positions the worker as a non-expert ... whereby the user can actively redefine themselves, their problems and their preferred solutions ... The social work values of respect, self-determination and working from where the client is, are very consistent with such an approach. (p. 183)

While the impact of this recent theoretical development has yet to unfold, it is clear that the principles and techniques of SFT are considered, at least by some, as a potentially rich source of inspiration for social work practice, and congruent with the social work ethos.

### **CONCLUSION**

While it has its roots in the family therapy field and emanated from the brief strategic therapy school, SFT is now considered to be a social constructionist approach which has a wide

applicability beyond family therapy. It is an approach to therapeutic work which appears to fit with the social work ethos of respecting clients, emphasising self-determination, which aims to build upon the resources within and around clients, and which reframes the worker as a facilitator and collaborator as opposed to a technical expert.

The research studies reviewed indicate that SFT is as 'successful' in its outcomes as other brief therapies, and that it has been mined successfully by practitioners as a source of 'ideas' from which they can construct alternative possibilities with clients. Some of the more subtle research findings suggest that the use of the model may influence practitioners' levels of belief and hope in clients' abilities to change and also lead to a more co-operative relationship with clients. The research to date has not addressed the question of what impact using SFT has on practitioners.

The most significant criticisms of SFT have been

- (i) of exaggerated claims for its effectiveness and the paucity of rigorous scientific studies to justify its superiority; and
- (ii) of its omission of any structural or gender analysis of power relations within client systems and client-therapist systems and lack of attention to these in the therapy process.

From a feminist perspective, these charges remain proven.

Various 'readings' of the approach have been made by different social work academics, and these highlight the significance of individual interpretation in the use of theories by practitioners and theorists.

In the next chapter, the focus will move from social work and practice models to the change process itself – how do professionals learn and change? How should new ideas and concepts be introduced to practitioners? How do individual, organisational and professional perspectives inform this process?



## CHAPTER FIVE: CONTINUING PROFESSIONAL DEVELOPMENT

### INTRODUCTION

The literature on Continuing Professional Development and ‘In-Service’ Training is informed by theories from a range of fields. These include generic theories of learning, theories of training, and theories of organisational change. Some focus on individual cognitive and behavioural processes while others focus on organisational processes and priorities. Others are written from the perspective of the ‘in-service’ trainer or personnel manager.

In Part One of this chapter, aspects of this literature of relevance to my study will be reviewed. Factors will be identified which are of influence in the processes involved in the introduction and maintenance of change in areas of professional practice such as social work. The limitations of existing theories will be identified and a case made for the use of Innovation Diffusion theory (Rogers, 1995) as a more robust tool of analysis for this study of a change initiative.

In Part Two, the central features of Rogers (1995) theory on ‘Diffusion of Innovations’ will be outlined and defined, and Smale’s (1998) adaptations for the social work/social care field noted.

### PART ONE: INDIVIDUAL, ORGANISATIONAL AND PROFESSIONAL PERSPECTIVES

#### THE INDIVIDUAL PERSPECTIVE

##### *Theories of learning*

Horwath and Morrison (1999) identify four approaches to learning theory<sup>117</sup>. Of these, experiential theories<sup>118</sup> (Kolb, 1974; Bateson, 1973) are seen to have most relevance to education and learning in the field of social work, a view shared by others (Bilson, 1993).

Experiential theorists (Bateson, 1973; Kolb, 1984) have identified different levels of learning that can take place – primarily distinguishing between learning that adapts to deal with routine problems, and that which involves a change of mental models. In Bateson’s original model, distinctions were made between four levels of learning. Applying the model to social work practice, Bilson made the following distinctions:

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<sup>117</sup> They are: behavioural, cognitive, experiential and socio-cultural.

<sup>118</sup> Experiential learning ‘is based on the idea that learning is the continuous process of human adaptation to our physical and social environment. Knowledge evolves through the continuous relationship between individuals and the world around them. Therefore, learning occurs through the accumulation and reflection on experience which is an interaction between the internal world of the individual and what is going on externally’ (Horwath & Morrison, 1999: 46).

'Zero' learning occurs when nothing new has been learnt – 'where behaviour is predetermined by ... previous completed learning, such that every time the situation is encountered the response of the individual will be the same' (p. 48).

*Level I* occurs where the individual develops a set of behavioural alternatives from which to choose to respond to a specific situational stimulus.

*Level II* requires a transferability of learning, or learning to learn:

... which requires the subject to recognise that the context is one in which certain categories of responses are applicable. For example, a social worker who has the ability to use a number of different counselling approaches will require the ability to assess the particular situation they face and to judge what approach will be the best to apply. (Bilson, 1993: 49)

Level II also requires the ability to assess a situation for which a particular approach might best be applied and best developed through 'calibration' ('repeated practice in situations which themselves are essentially unique', p. 49). Bilson views calibration as crucial for social work education, as do Fook *et al.* (2000), who point to the need for social workers to develop context-specific theory and rules.

*Level III* is 'concerned with changes in the sets of beliefs and assumptions which are used to make sense of experience' (p. 50). Learning on this level is rare as it is related to 'sequences of (behaviour) in which there is a profound reorganization of character' (Bateson, 1973: 272, quoted in Bilson, 1993). Bilson gives the example of the adoption of an anti-discriminatory perspective by many UK social workers in the 1990s as a piece of Level Three learning which required 'changes in the previous habitual ways the person has developed of perceiving the world' (p. 50), although this is an assumption that practitioners who saw themselves as already adopting such a perspective might disagree with.

Learning is viewed as a cyclical process by Kolb (1984) (Figure 1) involving

... a cycle of activities which begins with some experience of data which may be disconfirming and concludes with the implementation of revised action in the light of intermediary steps which focus on processing and interpreting the data. (Coghlan, p. 28)

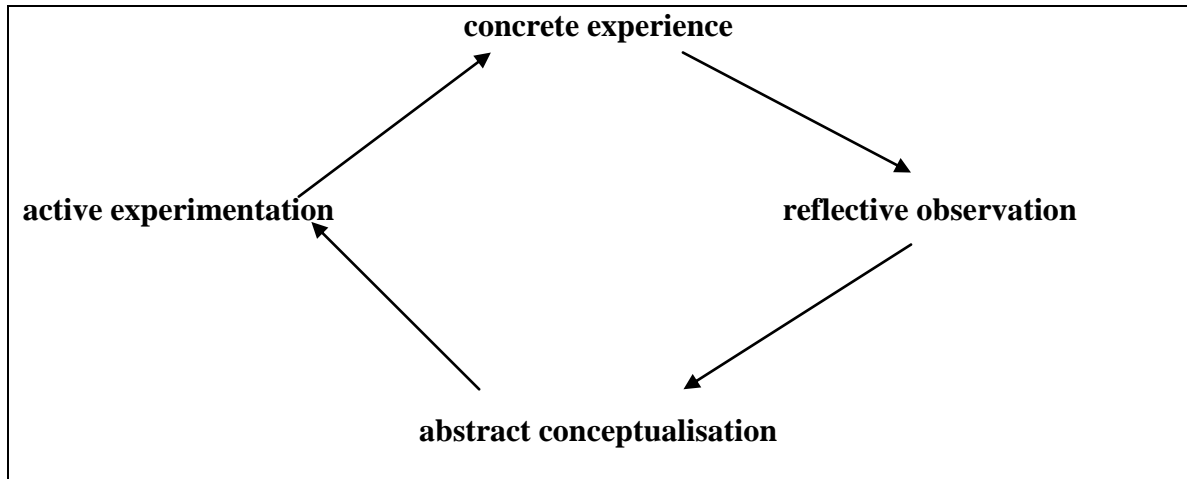
Horwath and Morrison (1999) in common with Fook *et al.* (2000) critique the dominance of individual theories of learning for the absence of attention to context within which practice takes place<sup>119</sup>. However, their analysis of this gap tends to remain superficial. In positioning training as an 'either/or' activity which supports or opposes a dominant culture, they risk playing into a form

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<sup>119</sup> They refer to the neglect by 'self-development theorists' of any consideration of 'the impact of socio-cultural forces on learning in terms of self-esteem, identity, motivation and access' (p. 54), and the 'role of learning either in securing compliance with a dominant culture or enabling individuals and groups to reflect critically on an understanding of themselves within their socio-cultural context' (p. 55).

of reasoning which is unhelpfully oppositional<sup>120</sup> and assumes a monolithic ‘dominant culture’, where one may in fact not exist<sup>121</sup>. Fook *et al.* (2000) acknowledge more fully than Horwarth and Morrison, the interplay of individual experience and contextual factors but locate their discussion primarily within the field of primary professional education.

Figure 1: Kolb’s Learning cycle (1984)



Taken together, the work of Kolb, Bateson, and Fook *et al.* is indicative of a trend which accepts that a technical-rational view of expertise is not appropriate for the understanding of the development of professional competence in fields such as social work.

Social work has certain qualities which militate against a technical-rational approach, because:

- both context and encounter are socially constructed;
- shifting realities exist dependent on the contingencies of cultural, political, social and economic influences;
- the unique characteristics of the individual learner and practitioner and the variety of processes involved in ‘meaning-making’ both individually and collectively need to be considered in any epistemology of practice; and
- individual and organisational learning are products of systemic processes whereby context, material and individual interact and affect each other at different levels and through feedback.

However, what has not been explored empirically to date is *how* these processes and various factors interact in the aftermath of a specific short course for qualified practitioners.

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<sup>120</sup> Fook *et al.* refer to the theory of ‘binary oppositional thinking’ (Sands & Nuccio, 1992) which ‘arises out of dichotomous thinking, a feature of Western thinking which categorises the world in terms of polar opposites which are seen as mutually exclusive, opposed to each other, and hierarchical ... and not interdependent’ (p. 154).

<sup>121</sup> Such as the context of practice at the time this study was taking place when the social system was in a considerable state of flux.

### *Learning and the development of expertise*

The field of social work practice, as exemplified by studies already cited (DHSS, 1978; Crousaz, 1981; Buckley, 1999) is often characterised by complex problems rarely amenable to routine solutions, although as noted by Eraut (1994) professional work can also include routine problems. The problems faced by social workers are only sometimes unstructured and ill-defined. Smith, Ford and Kowolski (1997) argue that in situations where task demands are less predictable, the traditional industrial-organisational training perspective has less relevance and needs to be supplemented by research from cognitive and instructional psychology, which unpacks the concept of learning and defines different types of expertise.

Smith *et al.* argue that three levels of expertise ('knowing how to do something well', p. 92) are possible:

#### *Novice expertise*

relies on the surface features of problems and uses heuristic search strategies (such as means-end analysis); does not have detailed domain knowledge and is not able to represent and understand problems in terms of deeper, structural features, relying instead on surface features.

#### *Routine (intermediate) expertise*

where familiar problems can be solved quickly and accurately as knowledge compilation and practice has led to automatic and efficient performance but where difficulty is experienced with novel problems; and

#### *Adaptive (expert) expertise*

where novel problems are tackled through the invention of new procedures based on knowledge and the ability to adapt to make new predictions and where the task is represented in relation to deeper structural features.

They argue that novices, intermediates and experts in their pursuit of solutions to specific practice tasks will differ in how they approach the task. Fook *et al.*'s (2000) subsequent study confirms that one of the features of expert practice in social work is the ability to frame problems in complex as opposed to routine ways and to create new alternatives as the situation demands in a less linear or deductive approach.

Both Smith *et al.* (1997) and Fook *et al.* (2000) agree that the building of adaptive expertise requires different training strategies than that of routine expertise. For Smith *et al.* (1997) training should concentrate on design strategies which emphasise learner control and mastery-oriented training in order to develop both meaningful knowledge structures and metacognitive abilities. Fook *et al.* (2000) recommend educational strategies focused on the inductive creation of knowledge from practice encounters, such as critical incidents and learning journals, and coaching which emphasises the importance of context in creating practice.

### ***Implications of theories of learning and expertise***

The implications of these theories of learning for this study are as follows:

- (i) In the case of the introduction of practice models such as SFT, one can hypothesise that depending on whether or not individuals are favourably inclined towards the model (as one that fits with their idea of social work) the type of learning involved varies. For those who are challenged by the training to change their attitudes, Level III learning is required; for those who are already in sympathy with the philosophy of the approach, Level II learning may be sufficient. Rather than viewing the complexity of the learning as conditional on the nature of the innovation or practice component, it is possible to view it as a product of the individual's orientation and interpretation of the innovation.
- (ii) Learning is maximised when individuals are given the opportunity to complete the entire learning cycle<sup>122</sup>. Alternatively, learning can be thwarted: by the individual being unable or unwilling to attend to educational experiences, having insufficient time for reflection or generalising, feeling unable to take risks in new situations: 'all of which leave the individual in a situation where life is routine and under control and learning does not take place' (Coghlan, 1997: 36). Again this suggests that it is in the interaction between individual and context that the complete experiential learning cycle is facilitated or hindered.
- (iii) Learning may not be an entirely comfortable experience, particularly when it involves changed behaviour and attitudes on the part of the learner, but 'disconfirming information'<sup>123</sup> can be the precursor to changed behaviours which involve new learning. The initial reaction to training therefore may not predetermine learning outcomes as suggested in the generic training literature. Even negative reactions may prompt subsequent reflection and/or experimentation.
- (iv) Depending on the dominant learning style of the individual, learners may vary in their acceptance or 'ease' with different stages in the cycle. Exposure to different processes in the learning cycle (e.g.: role-plays or experimentation; discussion; theoretical abstraction; planning further experimentation) can engender different responses from individuals.
- (v) Short courses (even those which aim to provide a more educative experience than technical training input) are likely to have a limited effect on people's practice, in the absence of measures which allow participants the opportunity to complete the different stages of the learning cycle.
- (vi) Practitioners with different levels of expertise and experience attending the same generic training course may have qualitatively different experiences both of the training and its

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<sup>122</sup> (1) experience or experiment with the new input, then (2) review of this experience, before (3) reflecting and drawing conclusions from it and finally (4) planning the next steps in taking this learning forward.

<sup>123</sup> Which challenges the individual's preconceptions.

impact, depending on whether the training was pitched at their level and depending on their individual cognitive abilities and experience level.

### **THE ORGANISATIONAL PERSPECTIVE**

Studies reviewed in Chapter Three suggest that agency function and organisational factors impact on the shape of social work practice. The extent to which practitioners feel able to implement new forms of practice may be affected by the perceived 'fit' between their agency function, organisational policies and priorities and the new form of practice involved. The literature on organisational training also suggests that specific features associated with different types of organisations will have an influence on learning.

#### ***The learning organisation***

The concept of 'the learning organisation' has gained currency in recent decades (Harrison, 1988; Senge, 1990; Thompson, 1995), and offers a model for an ideal organisational environment which promotes learning and the continuing development of its workers. As developed by Senge (1990) a 'learning organisation' is one where its members engage in five activities:

- personal mastery;
- building a shared vision;
- explicating mental models;
- team learning; and
- systems thinking.

The importance of a strong culture is emphasised in which staff hold a shared vision, or commitment to the aims of the organisation.

As outlined in Chapter One, the commissioning agent for this training event, the local Health Board was found to fall short of a 'learning organisation' in that there was a lack of reflective learning and constructive feedback, and insufficient attention paid to the explication of the mental maps employed by employees (Joyce & Kenefick, 1997).

#### ***Organisational learning and organisational change***

Coghlan (1997) views organisational learning as a 'dynamic interlevel process' within an organisational system. Two features are important:

- (i) an organisation is an 'open system' and its ability to learn and change

... is contingent on its degree of openness and ability to sense disconfirming information in the external or internal environments and to act on it while managing the systemic implications' (p. 29); and

- (ii) organisations as ‘recursive’ systems contain ‘patterns of feedback loops and sequences of interaction which link and integrate elements of a system’ (p. 29). Change initiatives should take account of the feedback loops and sequences of interaction and communication between the various individuals and levels within an organisation which either promote or discount individual and collective learning.

Coghlan argues that many organisational change initiatives pay insufficient attention to the intermediary levels where team and inter-team processes and dynamics occur. Thus, ignoring the extent to which learning takes place within a set of relationships.

The importance of the team dimension in learning is recognised by Horwath and Morrison (1999) who suggest that

... the concept of the learning team is often more viable than that of a learning organisation, because an organisation is often dogged by bureaucracy and political unpredictability, whereas a team, or smaller working unit, may be more in control of its destiny and much clearer about its learning needs. (pp. 153-4)

Because individuals and sub-groups within organisations are change at different rates:

A snapshot of an organization taken at a specific point in a change process would typically show that some groups in the organization are actively promoting the change agenda, some groups are beginning to feel the impact of the change, other groups are tentatively responding to it, and there are others, perhaps, whom the change has not yet touched. (Coghlan, 1997: 32)

Such systemic analyses contribute an increased understanding of the multi-factorial nature of organisational and individual change: they conceptualise the processes and inter-relationships between different sub-groups and systems which affect the training process and the impact of training events.

By drawing together (i) individual factors such as ability, motivation and personality; (ii) local factors such as workplace conditions, support and attitudes of managers/ supervisors, and team dynamics, (iii) inter-departmental processes and dynamics, and (iv) organisational and environmental factors, Coghlan’s framework offers a more sophisticated model for the analysis of individual and organisational change which emphasises strongly the role of the organisational climate and culture in influencing individual performance, change at the individual and inter-organisational levels, and the diffusion of innovation within organisations.

What is still missing from the systemic frameworks focused on the organisation however, is the wider context. Inter-agency and cross-organisational communication occurs within professional groups. In the case of social work in Ireland, practitioners and managers also relate to each other through professional organisations, trade unions, and formal and informal networks. An analysis of the impact of a cross-agency training event, such as the one which is the focus of this study,

therefore needs to adopt a wider framework which will allow for the influence of formal and informal networks which operate cross-organisationally.

## **PROFESSIONAL PERSPECTIVES**

### ***The significance of culture***

The culture of the organisation is viewed by many as crucial to the process of organisational learning. It has been defined as:

... the outcome of shared learning whereby mental models have been adopted and internalized by the members of an organization through its history in its efforts to adapt to its environment and organize itself internally. (Coghlan, 1997: 34)

The culture of the organisation can be either explicit or implicit but if underlying assumptions about such issues as the nature of power, the role of leadership, relative values and priorities remain unexamined, they can develop into 'cultural inhibitors' to learning. Effective team and organisational learning is maximised where teams and groups examine the processes governing their work as well as the content of such work:

... learning is enabled or inhibited in so far as individuals, whether in teams or across the interdepartmental group, do or do not engage in joint exploration of assumptions and reasoning processes. (Coghlan, 1997: 35)

Thompson *et al.* (1996), in considering the importance of culture as an influence on people's behaviour within a social work context, criticise the Human Resource Management literature for viewing culture as a 'simple, unitary matter' when it is 'complex and multi-faceted' and conclude that 'what we describe as 'the' culture is, in fact, an amalgam of various cultures or sub-cultures which operate within the organisation' (p. 648).

Viewing these sub-cultures as potential sources of tension and conflict within an organisation, Thompson *et al.* identify various sources of organisational culture, among them national culture, sector values, professional values, and individual beliefs and they note that social work, as a value-driven occupation, leads to a culture in social work organisations which is 'relatively strong and resistant to change, especially where professional values and moral principles are concerned' (p. 65).

### ***Local and tribal factors: Organisational culture(s) and professional ideology***

Empirical studies by Dalley (1989), Butler (1996) and Pithouse (1990) of the extent to which professional ideologies influence practice conclude that professional ideology and particularly the importance of 'guarding autonomy' (Pithouse, 1990: 42) are significant factors in understanding how professionals operate within organisational contexts.



### ***Differences between professional groupings – Dalley (1989)***

Dalley interviewed 236 individuals in three Scottish locations, drawn from a wide range of professional groupings within health and social services. She examined professional attitudes to a number of policy issues, concerning both the politico-moral domain<sup>124</sup> and the practical issues of resource allocation for the priority groups<sup>125</sup>. Defining ideology as ‘a patterning of beliefs and values relating to a view of the ordering of the world at relatively high levels of abstraction’ (p. 114), Dalley concluded that ideological differences emerged on politico-moral issues between different groups of health and social work professionals. She proposed that while:

*Professional ideology* relates to particular sets of values and moral attitudes, generally acquired implicitly over time through the training and induction processes of professional qualification; *organisational culture* is a means of drawing explicit boundaries around a group, imbuing the group with a view about itself that proclaims a distinctiveness as being characterised by particular behaviours and attitudes (whether or not it really is distinctive). It is the certainty that it is, and the allegiance to the group which that stimulates, that is significant – hence the label ‘tribalism’. (p. 115, my emphasis)

Taking the example of social work, she suggests that professional ideology and organisational culture may be mutually reinforcing. She concludes that:

Whilst a commonality of experience sometimes confers similar attitudes and reactions on disparate groups of professionals, it frequently goes unrecognised; fundamental differences existing at the ideological level ensure that the gulf – and concomitant hostility – remains. This may then be exacerbated and, at times, superseded by ties of tribal allegiance which are not necessarily grounded in genuine differences of view but are, rather, the product of unfounded and stereotypical assumptions about those located outside the inclusive boundaries of organisation and culture. (p. 116)

### ***Professional priorities versus organisational priorities – Butler (1996)***

An Irish study, exploring public health nurses views of new statutory child protection responsibilities in the early 1990s, found that the nurses’ views

... were considerably at variance with the officially stated commitment to inter-disciplinary collaboration and coordination ... the nurses defined their work roles in terms of their own traditional, professional commitment to individuals, families and communities, and felt less bound by or even aware of the corporate responsibility of their employing health board. (Butler, 1996: 303)

This research identifies the extent to which professional ideologies, identities and priorities may be at variance with organisational priorities. Different professionals may define their work in very different ways, neither adhering to an organisational definition nor achieving a professional consensus.

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<sup>124</sup> Questions for example about the balance of social responsibility for the care of dependent people, as between family and state.

<sup>125</sup> Covering, for example, the relationship between institutional and community care; the degree to which resources should be invested in prevention or withdrawn from the acute sector.

### ***Professional autonomy – Pithouse (1990)***

That professional and organisational sub-cultures develop in ways which create group identities and loyalties is illustrated by Pithouse (1990) in his study of a local authority social services area office in the UK. He concluded that the social workers in this setting acted as ‘guardians of autonomy’, creating:

... a group response to their environment that seeks to reject or manipulate external influences in such a way as to protect their accustomed forms of practice. (p. 43)

The organisational conduct of these social workers could be understood best by seeing them as a group in competition with management over the control of work, where:

power is not simply drained off by higher management but is contested and negotiated by those lower down who share similar views about their occupational task and identity. (p. 43)<sup>126</sup>

Pithouse concluded that social workers enjoyed and protected a considerable degree of self-regulation which permeated down to their way of organising their work. The workers decided their own priorities for visiting clients, rationed their time and energy in light of their own experience of case requirements, and applied their own preferred modes of intervention using the skills and types of relationships they felt most comfortable with. Their autonomy was evident in that: ‘While they respond to the erratic demands made upon them, they do so with scant interference from supervisors, managers and team colleagues’ (p. 45).

Pithouse argues that the protection of this level of autonomy is a priority for these workers and that ‘administrative intrusion in any shape or form is viewed as an unwarranted distraction or managerial threat to their accustomed self-regulation’ (p. 46). While he does not extend this resistance to organisationally-directed training or ‘continuing development events’, the question is raised whether training in itself when organisationally imposed is perceived as an interference and/or a threat.

### ***Implications of these studies***

It cannot be assumed that organisational rules, priorities and training initiatives will be accepted by sub-cultures of professionals such as social workers. This may be even more the case for workers operating within a system which has allowed them a great deal of autonomy and self-regulation, as had been the case historically for social workers in the health boards in Ireland.

The existence of professional sub-cultures, locally based and defined, bound together by group loyalties and identities which privilege the views and the support of colleagues above that of

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<sup>126</sup> This point is reminiscent of Sibeon’s sociological analysis of social workers active participation in the social construction of particular social problems as cited in the previous chapter.

administrators suggests that influence can run laterally across groups and will not necessarily run horizontally along hierarchical lines.

The implications for the introduction of change into social work services is that the influence of the professional group, and subgroups or cultures operating in different locations need to be considered as potentially key variables in the process. If social workers act as arbiters of good practice, then what impact does the assessment by peers of innovations introduced into the system have on the maintenance or abandonment of change?

## **THE LITERATURE ON TRAINING**

### ***Contemporary theories of training***

In-service training activities account for most of the work of training units in social care fields, but the literature varies in the extent to which goals of training are *organisationally* or *individually* focused.

Goldstein (1993) suggests that the goal of any training programme is to impart to *individuals* a new set of skills, knowledge, behaviours, or attitudes. Horwath and Morrison (1999) view training from an *organisational* perspective and define it as

... an organisationally initiated process intended to foster learning and competence throughout the workforce in order to meet the needs of service-users, contribute towards organisational goals and meet the professional development needs of individual staff. (p. 34)

The training process and its impact are affected by a number of factors operating at different levels and different points in time during and after the training process itself (Reid & Barrington, 1994; Buckley & Caple, 1994; Coghlan, 1997; Baldwin & Ford, 1988, Quinones, 1997). Individual, environmental and organisational factors are dynamically inter-related and instrumental in the effect of specific training courses. In the provision of training which occurs outside the workplace and is formally structured, such as the short course under examination in this study, the most critical aspect is the transfer process, a view which is shared by contemporary trainers within the social services field:

If knowledge and learning occur in the context of their use, this means that the process of transferring and translating theory, values, knowledge and skills from training to the job is a highly complex one. (Horwath & Morrison, 1999: 61)

### ***The Transfer Process***

Positive transfer of learning is defined as the degree to which trainees effectively apply the knowledge, skills and attitudes gained in a training context to the job ... for transfer to have occurred, learned behavior must be generalised to the job context. (Baldwin & Ford, 1988: 63)

Citing the growing recognition of the ‘transfer problem’ as of major importance to training researchers and practitioners,<sup>127</sup> Baldwin and Ford (1988) reviewed the existing transfer research and identified the core factors related to the transfer process.

### *Individual factors influencing the transfer process*

#### *Motivation*

There is abundant anecdotal and research evidence to support the notion that learning is inhibited seriously if a trainee has no desire or is not motivated to learn. Motivation can be defined ... as that which energises, directs and sustains behaviour or performance. (Buckley & Caple, 1994: 144)

Motivation is a complex concept influenced by the kind of rewards that are involved in learning, such as achievement (the reward is success), anxiety (the reward is the avoidance of failure), approval, curiosity and acquisitiveness (Reid & Barrington, 1994). Learners can be motivated both by anxiety and achievement. The reward of approval in its many forms may also be pertinent. Curiosity is ‘one of the trainer’s most powerful allies and should be nurtured by building on the learner’s interests whenever practicable’ (Reid & Barrington, 1994: 108). People are therefore multi-motivated, and motivation is affected by the immediate experience of the learner, both during and after training. It is also affected by intellectual ability to learn, and ‘physical readiness’: conditions such as ill-health and fatigue have an adverse effect on motivation (Buckley & Caple, 1994). Involving learners in setting training objectives, and giving them feedback both during and after training is an important component in maintaining motivation and maximising learning. Goal-setting can also be a motivational strategy which enhances the transfer of learning from training back to the work-setting (Reid & Barrington, 1994; Buckley & Caple, 1994). The evidence as summarised by Baldwin, Magjuka and Loher (1991) suggests that although motivation and ability are often considered together, they should be distinguished. Even if individuals possess the requisite ability to learn, performance will be poor if motivation is low or missing.

Reid and Barrington (1994) point out that motivation is not merely a matter of individual preference or choice but is also affected by the organisational orientation towards training and characteristics of groups within organisations. Referring to the first they argue that in most organisations, centralism and authoritarianism are key management philosophies which:

... assume that learners will not or cannot take their own decisions on learning; those decisions must be taken as a result of a bureaucratic process and imposed by ‘someone in authority’ ... such cultures might themselves be criticised in rarely providing for learner motivation ... [and] ... is an important element in any training plan. (p. 65)

Specific groups or sub-groups of learners within organisations may vary in their degree of conformity. Conformist learners remain dependent on direction and a centralised lead, whereas

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<sup>127</sup> Baldwin & Ford estimated that no more than 10% of the annual expenditure of \$100 billion on training and development in USA industries actually resulted in transfer to the job.

non-conformist alternative forms of action develop ‘from the fringe’ where innovation is encouraged or permitted to develop.

### *Learner choice*

Adult learning theorists suggest that because adults only learn when they feel a desire to learn, involvement in the selection of training may be an important motivator. Hicks and Klimoski (1987) reported that trainees who perceived they had a high degree of freedom to attend training reported more favourable post-training reactions and had higher achievement scores than those who perceived they had little freedom in their choice to attend. Baldwin *et al.* (1991) conducted their own vigorous study<sup>128</sup> to measure the effects choice of training had on both trainees motivation and learning, and also what effects *choice denied* decisions had on these outcomes. Their results confirm ‘the significant effects of the provision of choice and subsequent reception or rejection of that choice on trainee motivation to learn and learning outcomes’ (p. 324): trainees who received their choice had a higher level of motivation to learn prior to participation in the programme (although there were no significant differences in actual learning between those who received their choice and those not given a choice). But those offered a choice but then denied it had both a significantly lower motivation to learn *and* worse learning outcomes in what the researchers term ‘a frustration effect’. From an organisational training perspective ‘Choice may be a good thing only when trainee choice is ultimately reflected in the training received’ (p. 326). Hence, they emphasise the ‘perils of participation’ whereby offering choice but then not providing it might contributing to lower motivation and poorer learning outcomes than not offering any choice at all. Choice then should only be offered where provision is guaranteed.

Quinones (1997) notes that whether participants had volunteered or were sent on a training course was found in another study<sup>129</sup> not to have influenced learning outcomes directly but to have influenced trainee reactions confirming ‘an interaction between trainee motivation to learn and reactions on learning’ (p. 187).

Motivation therefore needs to be considered in relation to the personal and organisational factors which motivate individuals to attend and learn from a training event, and also to the factors within the training process which either encourage or inhibit motivation on the individual and group level.

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<sup>128</sup> Involving 242 research subjects who took up the offer of a short course (run 9 times in a university setting) on practical business skills at no cost. When enrolled, trainees were randomly allocated to one of three groups (no choice of content; choice – but choice not received; choice – with choice received). All trainees completed a measure of general cognitive ability – to control for ability. A pre-training motivation measure was administered, and after the training, several outcomes measures (relating to post-training motivation; and two different learning measures) were administered.

<sup>129</sup> Matheiu, Tannebaum & Salas (1992).

Quinones (1997) argues that motivation can affect whether or not an individual decides to attend a training session in the first place, the amount of effort an individual will exert during the training and whether or not an individual chooses to apply the trained skills on the job subsequently. Building on the premise that an individual's level of motivation is dependent on internal and external factors, he maintains that environmental (or 'contextual') factors present *before and after* training impact on motivation both to learn and to transfer learning to the work setting.

### *Ability*

‘Their (trainees) basic capacity for learning in general and their specific aptitudes or trainability in respect of certain forms of training content undoubtedly will be critical’ (Buckley & Caple, 1994: 139).

Quinones (1997) suggests that the ‘ability’ factor needs to be examined developmentally, in relation to the level of experience and expertise which individuals may possess at different points of their careers. This point is emphasised by Fook *et al.* (2000) who have demonstrated the developmental issues involved in the establishment of social work expertise.

### *Personality and personal factors*

Baldwin and Ford (1988) cite two aspects of ‘personality’ which have been found to be linked to the successful transfer of learning from course to workplace: a high personal need for achievement; and strong internal locus of control, but they note that other studies have found that personality factors had no effect at all on learning transfer.

Little has been written about the issue of personality in social work practice, although specific skills such as creativity and flexibility are now seen as important in the development of social work expertise (Fook *et al.*, 2000).

Personal factors, as opposed to personality, are seen to have an effect in the amount of energy and attention learners have available both during and after training; for example, those with personal, family or health problems may have less energy and concentration to engage with the material offered than others.

Additional personal characteristics which have been cited by Quinones include:

self-efficacy;  
attributions;and  
attitudes.

*Self-efficacy* refers to ‘an individual’s expectations regarding his or her future level of performance on a task’ (p. 180) and has been shown in a number of studies to be related to training effectiveness. Because individuals rely on many situational cues to establish their level of self-efficacy, feedback on performance is significant in promoting a sense of self-efficacy on the part of the learner:

Successful past performance leads to high levels of self-efficacy, whereas failure results in lower levels. Attributional evaluations of this feedback can enhance or mitigate the effects of feedback on self-efficacy. (Quinones, 1997: 183)

Coghlan identifies two other factors on the individual level that can affect attempts to introduce change:

- (i) the different rates at which individuals learn and change; and
- (ii) the individual psychological processes which shape how individuals react to change. He identifies four processes: denying, dodging, doing and sustaining, which track the order in which learning and change move from individual to the organisations as a whole.

Denying and dodging are natural reactions to the unexpected change news that change is needed. They describe more explicitly the specific reactions in the unfreezing process as experience is disconfirmed and anxiety felt ... the initial reaction to change to be expected is that change is not necessary and that such a reaction typically shifts to an avoidance or dodging stance. (Coghlan, 1997: 32).

### ***Work-environment characteristics influencing the transfer process***

Context matters. Training does not operate in a vacuum. (Quinones, 1997: 193)

Studies reviewed by Baldwin and Ford (1998) and Quinones (1997) suggest that (i) *work climate*, (ii) *leadership climate* and (iii) *supervisory support* were three important factors which affected the transfer process. Quinones (1997) views organisational contextual factors as central to the effects of training not only through the transfer process but on their impact on trainee characteristics *prior* to the training: ‘they represent higher order variables that are perceived by individuals and influence their thoughts and actions’ (1997: 181) and have an influence on motivation to learn, sense of self-efficacy and fairness perceptions<sup>130</sup>.

#### *The work or organisational climate*

Baldwin and Ford (1988) note that while the organisational climate is important, *how* it is important or *what aspects* are important needs more empirical investigation. Quinones emphasises the importance of the *perceived* environment which he terms *the climate*.

... climates are perceptions of the environment that evolve out of the interaction among organizational members. During these interactions, individuals attach meaning to

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<sup>130</sup> Sensitivity to the process used to arrive at training decisions as well as the actual training decisions themselves.

organizational features and events as they engage in a process of sense-making. (Quinones, 1997: 190)

Distinguishing between *organisational climate* (which exists when a group of individuals share a common perception of the work context) and *psychological climate* perceived by an individual, he suggests that perceptions of whether the organisational climate is broadly supportive or not affects trainees motivation to learn. The value of training to the organisation and the ways in which the organisation ‘frames’ training is suggested by Quinones as a relevant factor:

Organizations can also create the context for training through the information they provide trainees about a training program ... it is the perceived framing of the training program that will determine how a trainee reacts. (p. 188)

Quinones also suggests that *participation in training decisions* is a contextual factor of influence, namely the voluntary or compulsory nature of trainee attendance. Choices that trainees make are likely to reflect their self-assessed ability to benefit from the selected training course so, those who opt to go on particular courses are likely to have relatively high levels of self-efficacy compared to trainees who have been forced to attend either by their supervisors or organisational policies.

Trainee perceptions of situational constraints such as materials and supplies, time, information or equipment, are also of significance – they can frustrate a trainee’s attempt to translate knowledge and motivation into changed behaviours and attitudes in the workplace and can also lower self-efficacy (Quinones, 1997).

#### *Leadership climate and supervisory support*

Baldwin and Ford (1988) suggest that ‘employees who perceive that a training program is important to the supervisor will be more motivated to attend, learn, and transfer trained skills to the job’ (p. 93); thus supervisors have a critical role to play in promoting or discouraging the trainee in practising or implementing new skills and behaviours. By reinforcing the use of a new skill through specific task and goal setting or conversely by ignoring or actively discouraging it, supervisors can facilitate or extinguish new learning.

#### ***Evaluation of training***

Training is typically evaluated by measuring either training or transfer outcomes:

Training outcomes are measures gathered during or immediately after training, whereas transfer outcomes are gathered at a later point in time, typically in a different setting. (Quinones, 1997: 179)

One of the earliest, but still most frequently used, models for the assessment of training is that of Hamblin (1974) who developed his model for industrial training. His model has been recommended for use in general personnel development (Buckley & Caple, 1994) and for training in social services (Bramley & Pahl, 1996).



Bramley and Pahl (1996) suggest that there are five different types of evaluation possible: (i) goal-based; (ii) goal-free; (iii) responsive; (iv) systematic; and (v) pre-programme. Goal-based measures such as Hamblin's (1974) are still most commonly used. Hamblin's model assumes that there is a cause-and-effect chain linking five levels of training effects:

TRAINING leads to REACTIONS<sup>131</sup> which lead to LEARNING<sup>132</sup> which lead to CHANGES IN JOB BEHAVIOUR<sup>133</sup> which leads to CHANGES IN THE ORGANIZATION which lead to CHANGES IN THE ACHIEVEMENT OF ULTIMATE GOALS.<sup>134</sup> (Hamblin, 1974: 15)

Bramley and Pahl (1995) suggest that in agencies such as social services, the quality of the service may form the ultimate goal and may be process rather than product oriented. Hamblin also suggests that organisations such as hospitals, welfare organisations and even Government departments may 'give priority to some kind of measurement of *human good* over purely financial criteria' (p. 22, original emphasis).

Training is viewed by Hamblin as having value to individuals in the form of improved financial reward, job-opportunity, self-esteem. Some valued ends for the trainees can be immediate: enjoyment of the course as an end in itself; others may occur later: increased self-respect arising directly from learning and behaviour change, and the *effects* of the course attendance 'ticket' or certificate on future career prospects.

Despite its recommendation as an evaluation model for social services (Horwarth & Morrison, 1999) there are limitations to Hamblin's model. The depiction of the impact of training as occurring on the individual level alone presumes that learning takes place in a closed system without outside influence from the web of relationships which surround the individual. The assumption that pre-training definition of objectives can be defined in a unitary manner is questionable; a pluralist view (Bramley & Pahl, 1995) may be more appropriate for social care training where different groups (and individuals in one group) can have both different needs and objectives. Goal-based evaluation, centred on pre-defined objectives, miss out on informing the evaluator of unintended effects, and so is restricted to the anticipated effects only.

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<sup>131</sup> 'Reactions' are highly complex and keep changing over time. Reactions are influenced by 'their previous state of knowledge about, and attitudes towards the trainer, the other trainees and the subject-matter; by events (both training events and other events) in the recent past and events anticipated in the near future and by their present mood or state of mind' (Hamblin, 1974: 16).

<sup>132</sup> Learning is defined as 'the ability to behave in new kinds of ways' (p. 17). The evaluation of training effects takes place by the obtaining of information about the amount and type of learning which trainees acquire, also dependent on reactions: 'people who react inappropriately will fail to learn appropriately' (p. 18).

<sup>133</sup> Job behaviour is the extent to which trainees apply their learning to the job. The formulation and evaluation of learning in terms of behavioural change is viewed as necessary by Hamblin.

<sup>134</sup> Organisational and Ultimate Value are viewed as inter-connected, with organizational effects being the extent to which changes in the trainee's job behaviour impacts on the functioning of the organization in which they work, while ultimate value effects may vary.

### *Individual factors for social work*

That motivation, ability and personality/ personal factors are inter-related and influential in the impact of training and the success of the transfer process is strongly suggested by these general studies. The literature specific to the social work field suggests that social workers may be motivated by a number of factors to attend post-qualifying training but how their motivation is affected by conditions and actions both prior to and following training has been under-explored.

Social workers may attend training courses for various reasons: professional responsibility, as an antidote to the stress of the job, as a way of keeping practice 'sharp', promoting co-operation between workers across divisional and specialist boundaries, and introducing and promoting changes in work practice resulting from changes of direction politically, ideologically or both (Pritchard, 1986; Scally & Beyer, 1991; Barr & Shaw, 1995).

### *Professional responsibility*

Professional training for social work has tended to emphasise the need for continuing professional development: newly qualified social workers are seen to be 'beginning professional practitioners', who are expected to continue their development after qualification. Social work textbooks emphasise this:

Building and expanding one's knowledge base is an ongoing responsibility ... A lifelong challenge, the openness to continual learning is critical in developing professional competence. (Compton & Galaway, 1994: 583)

Irish social workers are expected to continue to develop their professional expertise after qualifying; an expectation that they appear to fully subscribe to, as interest remains high in most forms of post-qualifying education and training.

### *As an antidote to stress*

Social work journals, both in the UK, and in the USA, have in recent years devoted attention to the concept of 'stress' in social work, both as a cause and an effect (Davies, 1998). Empirical studies have examined levels of stress, comparing these levels between professional groups within the caring professions and identifying protective and risk factors (Tracy *et al.*, 1992; Gibson, McGrath and Reid, 1989; Thompson *et al.*, 1996; Collings & Murray, 1996). The traditional wisdom amongst social workers, managers and educators had been that the 'Holy Trinity' of support, supervision and training (Manning, 1996) was sufficient to protect social workers from stress. However, more recently there has a growing awareness of the importance of organisational contexts, practices and pressures within which workers operate. The literature on stress now tends to emphasise these factors more than individual psychological conditions (Davies, 1998); in addition the importance of individuals perceptions of demands and stress, and the value of personal coping strategies have been recognised (Collings & Murray, 1996). While the literature relating to

stress in Irish social work is undeveloped, studies such as Fulham's (1997) into staff retention problems in one community care social work team revealed that 80% of respondents cited stress as a main factor in their decision to resign from their jobs, indicating that it is a feature of some importance in the Irish context also.

Empirical studies of sources of stress and support are less clear-cut in their findings on the importance of continuing training. The strongest connection appears to be in relation to the satisfaction that workers derive from the opportunity to improve and develop skills and practice (Himle, Jayaratne & Thyness, 1986). Another study identified frequency in not feeling empowered to answer or solve specific client problems as the main feature of client-related work which contributed to feelings of stress amongst social workers (Collings & Murray, 1996). A statistically significant inverse relationship was found between viewing the opportunity to increase knowledge and skills as a source of job satisfaction and emotional exhaustion in another (Tracy *et al.*, 1992).

### *Maintaining morale*

Pritchard's review of the Staff Development and Training work of a large local authority in the UK in the mid-Eighties appears to bear out the notion that good staff development and training 'not only enhances motivation but also can play a major role in maintaining staff morale' (Pritchard, 1986: 3). Scally and Beyer (1991) found that in a mental handicap service, an in-service training initiative appeared to boost confidence, assertiveness and morale amongst the staff who took part.

Warnings have been sounded however about the extent to which professional autonomy can be threatened by organisationally-driven training: Carter, Jeffs and Smith (1995) see potential dangers in the provision of in-service training and argue that:

... training is often perceived as a benefit and gift, an interpretation continuously enhanced by locating it in expensive settings resplendent with elaborate cuisine. Sadly, there is no such thing as a free lunch. The cost that is extracted for this largess is the acquiescence of social workers, a denial of their right to professional autonomy and a reinforcement of employer control. For employers the investment is often productive, creating an intellectual 'dependency culture' amongst social workers, which serves to discourage collective attempts seriously to take responsibility for their professional development. (p. 176)

Post-qualifying training may be seen to have a role in preventing stress through giving workers the opportunity to develop skills. It may be of particular value where it enhances the workers' sense of ability to answer or solve specific client problems, but an additional factor is also the individual worker's perception of opportunities to increase knowledge and skills – some may view this positively, others may see it as a threat. The extent to which workers freely chose to go on training courses, and the impact this may have on the learning achieved is suggested but not verified in these social work-specific studies to date. For the professional worker, in-service training opportunities may either enhance or threaten professional autonomy; for the employer it may aim

to standardise varied professional practices. One could also include in these multiple realities that of the client who finds the practices of social workers changed by in-service training. In-service training has potential effects for a variety of ‘stakeholders’ in the social work process, and what may be viewed positively by one set of stakeholders may be experienced negatively by another.

### *Limitations of the training literature*

#### *The presumption of consensus*

Much of the literature on training assumes a consensus model of behaviour:

There needs to be a coherent and well-planned integration of training, education and continuous development in the organisation if real growth at individual and organisational levels is to be achieved and sustained. (Harrison, 1992: 4)

The organisation is assumed to be harmonious with consensus between its different levels. In some texts, there is an acknowledgement that convergence of individual and organisational aims cannot be taken for granted but the relative balance of power between individuals, sub-cultures and organisations is neither acknowledged nor explored and so the analysis remains simplistic:

If people are to form new views about how they should relate to the organisation, they must be encouraged to be self-critical ... This means they must feel able to admit errors, and learn from them, as well as taking risks in trying out new values and patterns of behaviour. (Harrison, 1992: 162)

The possibility of conflict existing between individuals and organisational values and aims is neither acknowledged nor addressed. Instead the assumption is made that values and aims are unambiguous, an assumption that is problematic when one considers the contested nature of social work practice as outlined in previous chapters.

#### *Industrial-organisational roots*

A second difficulty with this literature is that it has generally developed and been applied to industrial and commercial organisations rather than public, non-profit making social services. Interpersonal skills, a central aspect of social work practice, does not generally feature in the research upon which much of this theory is based. Studies carried out have been critiqued for this very reason<sup>135</sup>.

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<sup>135</sup> In a review of a large number of studies carried out on the effects of training design, Balwin & Ford noted that:

The criterion measure of interest for all the studies was oriented toward training outcome. Typically, measures of retention were taken immediately after completion of the training task ... The task used limit generalizability to short-term, simple, motor tasks and memory-skills training. The use of such tasks is problematic, given that organizational training is often conducted to enhance individual competence on long-term, complex skills such as interpersonal communication and managerial problem-solving’ (Balwin & Ford, 1988: 278).

### *The narrow concept of training*

Within the human resources literature, training is a short-term ‘systematic process through which an individual is helped to master defined tasks or areas of skill and knowledge to pre-determined standards’ (Harrison, 1988: 3). This does not allow for the trainee to be an actor in the process, bringing his or her own critical faculties and cognitive processes to bear on the material being presented, nor does it allow for the processing of new information over time which may not necessarily lead to changed behaviours in the short term but which may, in conjunction with other processes, contribute to changes in the longer-term.

### *The predictability of work environments*

The traditional training perspective assumes that work environments are largely predictable and that training designs can be identified to prepare trainees to respond appropriately across routine job situations. An alternative approach is to assume that the changing elements in the workplace lead to a fair amount of unpredictability. (Smith *et al.*, 1997: 99)

Professional social work practice tasks are not always routine or predictable, nor do they necessarily remain constant over time. Minor professionals (Schon, 1991), or ‘semi-professionals’ (Toren, 1969), such as teachers and social workers, are described as those who ‘suffer from shifting, ambiguous ends and from unstable institutional contexts of practice’ (Schon, 1991: 23).

The extent to which post-qualifying training for social workers can be predicated on promoting routine responses is therefore questionable, although the development of the ‘evidence-based’ movement in the UK is heading precisely in that direction. This development has been criticised precisely on these grounds:

... evidence-based practice proposes a particularly deterministic version of rationality which is unsatisfactory ... [and] is derived from ideas based on optimal behaviour in a planned and systematically organized environment ... the tendency to separate processes into ‘facts’ and ‘values’ implicit in evidence-based procedures undermines professional judgement and discretion in social work. (Webb, 2001: 57)

### *Context*

Research on contextual factors affecting training has been limited and Quinones (1997) suggests that the most pressing research need in the general organisational training sphere is the identification and classification of contextual factors through qualitative research. The importance of context as a major factor influencing social work practice is suggested through empirical studies carried out at different points in time (DHSS, 1978; Fook *et al.*, 2000) but no studies exist which have researched the impact of contextual factors on post-qualifying training both in the pre-training and post-training context.

### *Concepts of Learning*

The tensions that exist between the organisationally-focused training literature, even that directed at the social care field, and the growing literature on the development of professional expertise can be exemplified by comparing the perceptions of learning in each. In the context of effective staff training in social care, learning is seen as

... an ongoing process. However, we need time to process the learning by reflecting, observing and making use of the experience, analysing and creating meaning from the experience. *Once we have done this* we prepare and actually apply the learning in practice. It is only at this stage that there is likely to be a learning outcome in terms of a change of practice. (Horwarth & Morrison, 1999: 324, my emphasis)

Eraut (1994) in comparison notes that the concept of generalising learning from academic (or training) to professional practice contexts is flawed because

... new concepts and ideas brought into these contexts have to be *transformed* [my emphasis] in order to become usable in contextually appropriate ways; and this transformation can also be viewed as a form of learning which develops the personal knowledge base of the professional concerned. *Therefore it is inappropriate to think of knowledge as first being learned then later being used. Learning takes place during use, and the transformation of knowledge into a situationally appropriate form means that is no longer the same knowledge as it was prior to first being used.* (p. 20)

Much of the training literature (e.g. Horwarth & Morrison, 1999) persists in viewing professional practices as amenable to standardisation and regulation through a formulaic approach to in-service 'training', despite token acknowledgement of theorists such as Eraut who have demonstrated that *use* in the practice context generates the personal knowledge which is then *owned* by the professional.

### **CONCLUSION**

The organisational theory on training is useful in identifying both ideal learning organisational features, and in highlighting the importance of organisational structure and culture on the impact of training, but is unable to accommodate fully the particular features present in professional social work practice in the public, non-profit-making sector. Many organisational theorists place the needs of the organisation first, and tend to assume employee allegiance to organisational aims.

Empirical studies conducted into the organisation of social work in the UK indicate that professional autonomy is a well-guarded prize and that attempts by employers to control or influence the organisation of social work are seen primarily as attacks upon this autonomy. The importance of both professional 'tribalism' and organisational culture as major influences on both the perceptions and activities of social workers and other health care professionals has been empirically identified.

The individual motivations of social workers to attend training events are diverse. Continued professional development has been accepted as one of the ways in which social workers are supported in emotionally difficult work, as a stress prevention measure, as a way of introducing wider organisational change and as a way of keeping practice sharp or up to date.

The extent to which short courses are concerned with maintaining or developing established patterns of practice, or alternatively are geared towards introducing changes or innovations in work practices is insufficiently explored in the literature, and needs to be supplemented by theories and discourses which are specifically related to the process of introducing change on the individual and/or organisational level (Coghlan, 1997), such as that of 'diffusion' theorists (Rogers, 1995).

The assumption that any particular short course can be assessed in isolation from the individual and environmental contexts and influences both before and after the event is questionable.

It is therefore proposed that for this specific event, based as it was on a particular practice innovation and being only one part of a growing momentum of interest in this specific innovation, the most useful framework for analysing the data is one which is premised on a systemic formula for understanding the change process within a professional group across organisational boundaries, and which starts by viewing the 'learning issue', that of SFT, as an innovation in social work practice (Rogers, 1995; Smale, 1998).

## **PART 2: DIFFUSION OF INNOVATION THEORY**

### **INTRODUCTION**

As outlined in Part One of this chapter, there are difficulties in attempting to analyse the impact of a short course for social workers in a particular practice method using the established frameworks from organisational training and learning theory alone. The literature on the diffusion of innovation provides a more useful framework for the interrogation of the data collected in this study.

Rogers (1962, 1971, 1983, 1995) mapped out a generic model of the study of innovation and the diffusion of innovation process, drawing on research from a variety of traditions originating in the early 20th century, including sociology, anthropology, geography, education, communication and marketing and management (Rogers, 1995). Now in its fourth edition, Rogers' model has remained influential. It has been applied to the social work field in the UK by Smale (1992; 1996; 1998) and in the USA by Herie and Martin (2002) who have proposed it as a model for the management of the introduction of innovation.

### **ROGERS' (1995) INNOVATION DIFFUSION MODEL**

Rogers' model views the process of change, or the introduction of new ideas into a system (individual, group or organisation), as consisting of four main elements: the innovation; communication channels; time; and the social system.

Diffusion<sup>136</sup> is the Process by Which (1) an Innovation<sup>137</sup> (2) is Communicated through Certain Channels (3) Over Time (4) Among the members of a Social System' ... The diffusion of innovations is essentially a social process in which subjectively perceived information about a new idea is communicated. The meaning of an innovation is thus gradually worked out through a process of social construction. (1995: xvii)

It matters little whether the idea is objectively new as measured by the period of time since its initial discovery or use: it is its *perceived* newness which is important. Newness in an innovation need not just involve new knowledge but may also be expressed in terms of persuasion or a decision to adopt or to try it out. People may know about an innovation for some time but have not yet developed a favourable or unfavourable attitude toward it, nor have adopted or rejected it.

Reframing innovations as solutions to problems, Smale suggests that innovations can then be seen as:

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<sup>136</sup> *Diffusion* 'is a particular type of communication in which the message content that is exchanged is concerned with a new idea. The essence of the diffusion process is the information exchange through which one individual communicates a new idea to one or several others' (Rogers, 1995: 17).

<sup>137</sup> Innovations: 'are ideas, practices, or objects that are perceived as new by an individual or another unit of adoption ... [which] presents an individual or an organization with a new alternative or alternatives, with new means of solving problems' (Rogers, 1995: 11).



... a better solution, an improvement on existing practices or equipment; a new solution to an old problem; a new solution to a new problem, or a solution to an old problem that does not have so many harmful, unintended consequences. (1998: 88)

Innovations have particular characteristics which are of perceived importance to would-be adopters. These are: (i) *relative advantage*,<sup>138</sup> (ii) *compatibility*,<sup>139</sup> (iii) *complexity*,<sup>140</sup> (iv) *trialability*<sup>141</sup> and (v) *observability*<sup>142</sup>.

**Re-invention:** is the degree to which an innovation is changed or modified by a user in the process of its adoption and implementation. Innovations which are flexible by nature

... are re-invented by many adopters who implement them in a wide variety of different ways. An innovation is not necessarily invariant during the process of its diffusion. And adopting an innovation is not necessarily the passive role of implementing a standard template of the new idea. (Rogers, 1995: 17)

Rogers' model includes the following key concepts:

**Communication channels:** Communication is viewed as:

... the process by which participants create and share information with each other in order to reach a mutual understanding ... Diffusion is a particular type of communication in which the message content that is exchanged is concerned with a new idea. (Rogers, 1998: 17)

The communication channel is the means by which messages move from one individual to another. Rogers makes a distinction between *mass media channels*, those means of communicating a message that involves a mass medium and enables a source of one or more individuals to reach an audience of many; and *interpersonal channels* involving face-to-face exchange between two or more individuals<sup>143</sup>. In this model *interpersonal communication* channels are seen to be more effective [than *mass media channels*] in persuading an individual to accept a new idea:

... most people depend mainly upon a subjective evaluation of an innovation that is conveyed to them from other individuals like themselves who have previously adopted the innovation. (p. 18)

**Time:** viewed as an essential element in the diffusion process in three influential ways:

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<sup>138</sup> Relative advantage: 'the degree to which an innovation is perceived as better than the idea it supersedes'.

<sup>139</sup> Compatibility: 'the degree to which an innovation is perceived as being consistent with the existing values, past experiences and needs of potential adopters'.

<sup>140</sup> Complexity: 'the degree to which an innovation is perceived as difficult to understand and use'.

<sup>141</sup> Trialability: 'the degree to which an innovation can be experimented with on a limited basis'.

<sup>142</sup> Observability: 'the degree to which the effects of the innovation are visible to others' (Rogers, 1995: 16).

<sup>143</sup> *Mass media channels* are 'means of transmitting messages involving a mass medium such as radio television, newspapers and so on, that enable a source of one or more individuals to reach an audience of many. Mass media can (1) reach a large audience rapidly, (2) create knowledge and spread information, and (3) lead to changes in weakly held attitudes. The formation and change of strongly held attitudes however is usually accomplished by *interpersonal channels* ... [which] involve a face-to-face exchange between two or more individuals' (Rogers, 1995: 194)

- (i) in the innovation-decision process by which an individual passes from first knowledge of an innovation through its adoption or rejection;
- (ii) in the innovativeness of an individual or other unit of adoption – that is, the relative earliness/lateness with which an innovation is adopted – compared with other members of a system; and
- (iii) in an innovation’s rate of adoption in a system, usually measured as the number of members in the system that adopt the innovation in a given time period (Rogers, 1998: 20).

**The innovation-decision process:** the mental process through which an individual passes from first knowledge of an innovation to forming an attitude towards the innovation, to a decision to adopt or reject, to implementation of the new idea, and to confirmation of this decision (p. 36).

**Types of knowledge:** There are three types of knowledge that are important in the introduction and diffusion of innovation:

- *firstly, awareness-knowledge:* ‘information that an innovation exists’ (Rogers, 1995: 165), which then motivates an individual to seek more knowledge in the form of
- *‘how-to’ knowledge:* ‘information necessary to use an innovation properly’ (p. 165), and
- *‘principles-knowledge’:* ‘information dealing with the functioning principles underlying how the innovation works’ (p. 166)<sup>144</sup>

**Innovativeness of adopters:** This is ‘the degree to which an individual or other unit of adoption is relatively early in adopting new ideas than other members of a social system.’ (Rogers, 1995: 22).

Five adopter categories are specified in Rogers’ model as *ideal types*<sup>145</sup>:

*Innovators*

... are active information-seekers about new ideas. They have a higher degree of mass media exposure and their interpersonal networks extend over a wide area, reaching outside of their local system. Innovators are able to cope with higher levels of uncertainty about an innovation than other adopter categories. As the first to adopt a new idea in their system, they cannot depend upon the subjective evaluations of the innovation from other members of their system. (p. 22)

*Early Adopters*

... are a more integrated part of the local social system than are innovators. Whereas innovators are cosmopolites, early adopters are localites [and] has the

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<sup>144</sup> Rogers notes that many efforts to introduce innovation concentrate on developing awareness-knowledge but that ‘how-to’ knowledge is most essential for potential adopters. Principles knowledge become important to adopters if they run into difficulties in using the innovation.

<sup>145</sup> ‘Ideal types are conceptualizations based on observations of reality that are designed to make comparisons possible ... Exceptions to the ideal types can be found ... Ideal types are based on abstractions from empirical investigations’ (Rogers, 1995: 263).

greatest degree of opinion leadership in most systems. Potential adopters look to early adopters for advice and information about the innovation ... they serve as a role model for many other members of a social system ... The early adopter decreases uncertainty about a new idea by adopting it, and then conveying a subjective evaluation of the innovation to near-peers through interpersonal networks. (p. 264)

#### *The Early Majority*

... adopt new ideas just before the average member of a system ... are the most numerous adopter categories, making up one-third of the members of a system ... [and] may deliberate for some time before completely adopting a new idea. Their innovation-decision period is relatively longer than that of the innovator and the early adopter. (pp. 264-5)

#### *The Late Majority*

adopt new ideas just after the average member of a system. Like the early majority, the late majority make up one-third of the members of a system. Adoption may be both an economic necessity ... and the result of increasing network pressures from peers. Innovations are approached with a skeptical and cautious air, and the late majority do not adopt until most others in their system have done so ... The pressure of peers is necessary to motivate adoption. (p. 265)

#### *Laggards*

... are the last in a social system to adopt an innovation ... many are near isolates in the social networks of their system. The point of reference for the laggard is the past. Decisions are often made in terms of what has been done previously, and these individuals interact primarily with others who also have relatively traditional values. Laggards tend to be suspicious of innovations and change agents. Their innovation-decision process is relatively lengthy with adoption and use lagging far behind awareness-knowledge of a new idea. (p. 265)

**The Rate of Adoption** is 'the relative speed with which an innovation is adopted by members of a social system' (Rogers, 1996: 22), and is usually measured by the length of time required for a certain percentage of the members of a system to adopt an innovation. Rogers suggests that most innovations have an S-shaped rate of adoption, but, based on his research and application of the model in British social services, Smale suggests that:

Ideas, new methods of work, and even new policies, rarely follow the straightforward linear path. The road taken by a new method, from idea to widespread implementation, is often a route full of bumps, twists and bends, brick walls, U-turns and tangential changes of direction. (Smale, 1998: 74)

**The Social System** is defined as:

... a set of interrelated units that are engaged in joint problem-solving to accomplish a common goal. The members or units of a social system may be individuals, informal groups, organizations and/or subsystems. (Rogers, 1996: 23)

The diffusion of a specific innovation within a specific social system is uniquely contingent on the specific features of the system in question:

... the system has a direct effect on diffusion through its norms and other system-level qualities, and also has an indirect influence through its individual members. (Rogers, 1996: 23)<sup>146</sup>

### THE IMPORTANCE OF PARTICULAR ACTORS

Rogers and Smale define different actors within social systems of importance in the adoption and diffusion process.

Smale defines '*Opinion Leaders*' within a social services setting as 'those people within an organisation or profession who have an influence on the methods used by others' (p. 110). They act as role models for others and are viewed as being of crucial importance in the diffusion of new ideas or methods, as they can either promote or block such innovations. Rogers suggests opinion leaders when compared with their followers, tend to be more cosmopolitan and more exposed to all forms of external communication; have somewhat higher social status and are more innovative. Their most striking characteristic however is 'their unique and influential position in their system's communication networks. They are at the centre of interpersonal communication networks' (Rogers, 1996: 27).

Smale suggests several categories of actors who influence the course of an innovation's introduction and adoption within social service settings:

*'Product champions'* – ... the crucial early adopters ... not only adopt new methods, but take up the cause of spreading the message to others. (p. 110)

*'Gatekeepers'* - control the allocation or the distribution of resources. In social services, Smale notes that often such gatekeepers are relatively low-status administrators who can stall changes in practice by not releasing resources:

These people can be effective gatekeepers, operating procedures which are frequently obsolete, in such a way that it is actually difficult to acquire the resources senior managers have released. (p. 112)

*Legitimate Initiators* are those accepted by their peers and managers as being entitled to introduce change.

... in some organisations, it is not possible to introduce bottom up innovation without senior managers rejecting initiatives from those they feel should only respond to initiatives from the top. There are also some staff whose attitude to authority is such that they will reject initiatives because they come from the top. (Smale, 1998: 113)

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<sup>146</sup> The structure of the system is seen as being a factor of importance in the diffusion of an innovation in two ways: firstly in relation to the social structure: 'the patterned arrangements of the units in a system' (p. 24); secondly in the less formal communication structures – 'the differentiated elements that can be recognized in the patterned communication flows in a system' (p. 24) that develop in any organisation or system.

*Minders*: are supporters of innovators or change agent, often someone in senior management who ‘supports them when the going gets tough’. Senior managers often play different roles – as sponsors, critics, mentors and institutional leaders; and also in this role as ‘protector’ of the innovator.

*Consequences* are ‘the changes that occur to an individual or a social system as a result of the adoption or rejection of an innovation’ (p. 37); and consist of:

- (a) *‘desirable versus undesirable consequences’*;
- (b) *direct versus indirect consequences*, depending on whether the changes to an individual or to a social system occur in immediate response to an innovation or as a second-order result of the direct consequences of an innovation; and
- (c) *Anticipated versus unanticipated consequences*, depending on whether the changes are recognized and intended by the members of a social system or not. (Rogers, 1996: 31)

#### **THE ROLE OF TRAINING IN THE DIFFUSION OF INNOVATION**

Smale has considered the role of short training courses in the diffusion of innovations in social services. Training, he maintains, is only one part of changing people’s practice:

If new skills are not to be quickly eroded by attempts to fit them into old customs and practices the organisation has to become a conducive context for both newly qualified practitioners and old hands who have developed new methods. (p. 197)

In his view, while workers in personal social services are often hungry to develop their skills and knowledge, ‘they are significantly less keen to examine and change their basic assumptions upon which their practice has been based’ (Smale, 1998: 206) and consequently short training courses are particularly limited when the innovation requires a change of attitudes and assumptions.

Smale’s observations suggest that a short training course in itself will have a limited impact on the sustainment of an innovation in the absence of support for changed practices in the workplace, and particularly from the line manager.

#### **THE POTENTIAL OF ROGERS’ MODEL AS A FRAMEWORK FOR ANALYSIS**

As already stated, the short course at the centre of this study, was an event organised within a particular agency for social workers but also attended by workers from other agencies. It was *not* an attempt to introduce an innovation organisationally, i.e., it did not have a health board wide mandate, and it did *not* attempt to influence other professional groups working within the health board. It was also an optional event – most individuals had a choice as to whether they attended or not.

Rogers' model offers a useful framework for the analysis of such an initiative in the following ways:

- It allows for the adoption of an innovation over time and across organisational boundaries.
- It enables a distinction to be made between the influence of 'mass communication' channels such as that of a training event, and interpersonal channels such as those between colleagues and peers.
- The characteristics of an innovation can be mapped according to the perceptions of those 'potential adopters' exposed to the innovation.
- The concept of 're-invention' allows for diverse forms of an innovation to be created and implemented. Re-invention may be of particular significance in the field of social work given the studies cited in Chapter Two about the extent to which social workers may use theoretical frameworks as a source of 'ideas'.
- The roles played by different actors can be mapped and an assessment made of their relative significance in the diffusion process which may lead to some illumination of the question of what role near-peers and managers play in influencing the course of an innovation.

The mapping of the innovation-decision process (Figure 2) as it relates to this specific training course will allow for the movement of the participants over time, between the training event itself and the time of interview.

- An overview of the factors affecting the impact of the training course in the introduction and diffusion of the innovation can be provided by identifying the different variables (Figure 3) and mapping them for this specific innovation.

Figure 2: Rogers' Model of Stages in the Innovation-Decision Process (1995: 163)

Figure 3: Variables determining the Rate of Adoption of Innovations (Rogers, 1995: 207)



## CHAPTER SIX: METHODOLOGICAL APPROACH

Research is ultimately about theorising a phenomenon. (Fook, 2000: 2)

### INTRODUCTION

Witkin (1994) has noted that the methodological lenses researchers use are of importance because they ‘may change how they interpret what they observe’ (p. 330).

This chapter articulates the nature of the lens employed to make sense both of the theoretical propositions identified in the preceding chapters and the empirical data from the study. The rationale behind the use of particular research methods will be discussed.

### AIMS OF THE RESEARCH

The first and most important condition for differentiating among the various research strategies is to identify the type of research question being asked. (Yin, 1994: 7)

As outlined in Chapter One the research questions posed in this study are three-fold:

- (i) How do social workers engage with, assess and incorporate theoretical innovations into their practice?
- (ii) What factors influence the processes of engagement with, and evaluation of, innovations in social work?
- (iii) What is the role of the short training course in this process?

For the first two questions, the field of study is primarily internal, relating to process and perceptions. The attitudes and opinions of respondents were therefore central, and the aim was to capture the meaning of SFT to social work practitioners and managers and to map out their engagement with it before, during and after the short course. This was achieved through an *inductive*<sup>147</sup> approach which elicited data from respondents without imposing pre-conceived concepts.

For the third question, a different perspective was necessary – one which would enable me to map out what, if any, progress through the innovation-diffusion process followed the short course. Some form of evaluation was necessary. This was conducted using Rogers’ (1995) theory as a tool of analysis, introducing a *deductive* aspect, as I looked for concepts based on earlier work.

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<sup>147</sup> ‘The inductive mode of reasoning [involves] moving from observed phenomena to a conceptualisation of their meaning’ (Fortune, 1994).

## A QUALITATIVE FRAMEWORK

The choice of a particular research perspective is not simply a technical matter, but a rational decision to choose the best design to fit a research question in pursuit of research excellence. (Trinder, 1996: 234)

Sarantakos (1993) has listed various situations in which qualitative<sup>148</sup> research is preferable to quantitative. In three respects, the qualitative framework fits the aim of this research and my orientation as researcher in this study:

...[1] there is a need to examine internal realities, i.e.: the meaning of the event for the participant ...[2] the investigator perceives researcher and researched as elements of the same situation and the research process as a whole unit (and) ...[3] the researcher wishes to capture the meaning and the regularities of social action. (Sarantakos, 1993: 107)

Qualitative methods are also said to offer practitioners/researchers the opportunity ‘to embrace research without submitting to the ‘context stripping’ and ‘reductionistic’ approaches of quantitative methods’ (Padgett, 1998: 373). Trinder (1996) suggests that qualitative analysis is useful in rendering complex processes and phenomena into manageable realities but warns that it must be done thoroughly.<sup>149</sup>

## RESEARCH PARADIGMS

Guba and Lincoln (1994) suggest that although the choice of either quantitative or qualitative methods can be important, ‘questions of method are secondary to questions of paradigm’ which they define as ‘the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways’ (p. 105).

Witkin (1994) makes a further distinction between methodology and method: ‘Methods refer to the techniques that are used in evaluation such as an interview or a statistical analysis. Methodology refers to the overall guiding framework within which methods are employed’ (p. 330).

In this case, whilst some counting takes place, the overall guiding framework is a qualitative one. This needs elaboration on a paradigmatic level because ‘*inquiry* paradigms define for *inquirers* what it is they are about, and what falls within and without the limits of legitimate inquiry’ (Guba & Lincoln, 1994: 108, original emphases).

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<sup>148</sup> Qualitative research is simply defined as ‘research that produces descriptive data based upon spoken or written words and observable behavior’ (Sherman & Reid, 1994: 1).

<sup>149</sup> ‘The strength of qualitative research has traditionally been seen as providing an opportunity to develop rich understandings of processes and people, trading off the breadth of explanation of quantitative methods for depth of understanding. To make the trade-off worthwhile requires considerable analytic effort. Understanding and theory-generation through qualitative data-analysis is a complex and demanding process of interpretation. It requires careful and comprehensive analysis of the data, generating categories and building up the analysis from the bottom. Without that effort and understanding, there is a temptation to under-analyse and ‘cherry-pick’ data, by selecting dramatic and interesting quotations and capturing superficial understandings’ (Trinder, 1996: 237).

The aim of constructivist inquiry is to: ‘understand the complex world of lived experience from the point of view of those who live it ... (accepting that) to understand this world of meaning, one must interpret it’ (Schwandt, 1994: 118). The constructivist paradigm allows for the existence of multiple knowledge or interpretations, ‘depending on social, political, cultural, economic, ethnic and gender factors that differentiate the interpreters’ (Guba & Lincoln, 1994: 113). Rodwell and Woody (1994) note that

Constructivist inquiry is predicated on the assumptions that the nature of reality is multiple, constructed, holistic, divergent; that generalizations are not possible or desirable owing to the context and time-bound nature of reality; and that interactive mutual shaping, not causality, can be discovered in a research process that recognizes the value-bound, interrelated nature of the inquirer and the object of inquiry. (p. 316)

Constructivists take the view that what can be considered as objective knowledge and truth is the result of perspective, where knowledge and truth are created and not discovered by mind (Schwandt, 1994). Knowledge as a product of the research inquiry is seen to develop in the interaction between inquirer and respondents. Consequently the position of the inquirer and their subjectivity is seen to be a central aspect of the inquiry. What is emphasised in a constructivist venture is that the researcher’s position be made explicit, and not assumed to be objective, unbiased or value-free. Taking into consideration the criticism that constructivist approaches disregard issues of power and context (Laird, 1994), and that the focus of my study aims to explore both the individual meaning-making process and the collective generation of meaning through social processes, this study straddles both the constructivist and constructionist paradigms.

The implications of the research being so located are as follows:

- (a) The researcher is not considered to be an objective and impartial observer of an external reality, but an integral participant in the creation of the reality being researched. The researcher’s own experiences and attitudes are therefore acknowledged as being of significant importance, and are fully outlined to enable the reader to evaluate the quality of the research.
- (b) Constructivism allows for a research inquiry to be considered as a form of ‘participatory inquiry’ (Shaw, 1996)<sup>150</sup> with the researcher and researched viewed as co-researchers with particular respect given to the validity of the participant’s perspective. This position does not however, deny the researcher’s interpretative role in analysing and making sense of the data collected.
- (c) The acceptance that there are many different perspectives to any given situation or experience requires the researcher to identify and explore different perspectives, noting both similarities and differences.

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<sup>150</sup> Although it is acknowledged that true participation would have involved returning to the respondents regularly to continue an interactive dialogue in relation to the construction of this ‘knowledge’.

- (d) The quality of a research design is to be judged in relation to trustworthiness and authenticity.
- (e) The social constructionist paradigm stresses the significance of the collective generation of meaning, affected as it is by the conventions of language and other social processes.

#### **USING THE RESEARCHER'S OWN EXPERIENCE**

Although there are different views about the extent to which social work practice and research *are* similar activities (Gilgun, 1994b; Padgett, 1998), practitioners bring a particular perspective to their research work which confers both advantages and disadvantages.

Fuller & Petch (1995) notes that, apart from established skills in interviewing and information-gathering,

‘day-to-day experience gives them [practitioner-researchers] an unequalled degree of insight into, and knowledge of, the real problems which face both clients and service providers...this knowledge and insight creates both the capacity to pinpoint the key general questions which research can most profitably address, and to understand the context of such questions in larger agency or community issues’ (p. 9).

My familiarity with SFT on both theoretical and practice levels and my established connections with practitioners enabled me as a researcher to develop a study of the approach on a more formalised research basis. I had insider-knowledge, the goodwill of former colleagues and I was, I hope, seen as trustworthy.

That the timing of the fieldwork coincided with my move from a practitioner to an academic post meant that I had the advantage of access to the field at the same time as a necessary distance from practice. Fuller & Petch (1995) note that one disadvantage of being a practitioner-researcher is that ‘practitioners may through habit-blindness have difficulty in seeing the wood from the trees’, and that to do research one needs ‘to stand back, to see a wider picture than is necessarily visible from the individual practitioner’s workload...[and] a certain distancing from the taken-for-granted conceptual and linguistic apparatus of the practitioner.’ (p.9).

My position and familiarity with SFT on both theoretical and practice levels brought not only advantages but also potential threats to the validity of the research project, and these needed to be addressed in the research design. By adopting a survey method of data collection, I maximised my existing relationships with ex-colleagues by carrying out all the fieldwork within a short intensive time period. By the time I came to analysis and interpretation I had achieved some additional distance and was, I think, able to be more objective both about SFT and about the data collected

## A CASE STUDY

Case study research is said to be appropriate when

... investigators desire to (a) define topics broadly and not narrowly; (b) cover contextual conditions and not just the phenomenon of study, and (c) rely on multiple and not singular sources of evidence. (Yin, 1993: xi)

That the researcher may be more interested in a particular case (as occurs here) than in one case as possibly representative of others, is not seen as a problem but is denoted in the literature as a particular type of study: *an intrinsic case study* ‘undertaken because one wants better understanding of this particular case ... because in all its particularity and ordinariness, this case itself is of interest’ (Stake, 1994: 237). The unique strength of the case study is said to be its ability to deal with a full variety of evidence – documents, artefacts, interviews and observations. It also allows for the use of more than one strategy in any given study, for example a survey within a case study. Yin (1994) notes that the case study as a research strategy has a distinct advantage over other strategies when a ‘how’ or ‘why’ question is being asked ‘about a contemporary set of events over which the investigator has little or no control’ (p. 9).

While the primary source of data was an in-depth survey of participants who attended a short course, the use of a survey *within* a case study design enabled me to draw on other relevant sources of data, such as documentary data. The context within which practitioners and managers were attracted to SFT, and to which they returned after the training, could not have been comprehensively addressed if a survey alone had been utilised. As Yin (1994) has noted: ‘Surveys can try to deal with phenomenon and context but their ability to investigate the context is extremely limited’ (p. 13).

Yin’s (1993, 1994) model for case study research assumes a single objective reality that can be investigated by following the traditional rules of scientific inquiry. This is in conflict with the paradigmatic aspect of this constructivist research endeavour which presumes multiple, shifting realities. Yin (1994) also takes the position that method rigour is more important than the question to be researched or the need for adaptability to unique conditions. For this study, Yin’s (1994) model was modified by inserting the constructivist criteria for the quality of a report (trustworthiness and authenticity) and by acknowledging the researcher’s attitudes, values and influence instead of assuming an objective, value-free, neutral inquirer (Guba & Lincoln, 1994).

Yin’s (1994) identification of the situations where the case study should be the design of choice and the clarity of his comparison of the case study with other research methods was of value and has been drawn upon. He emphasises:

- the importance of multiple sources of data;

- the importance of theoretical propositions in guiding the inquiry and in providing ‘theoretical triangulation’: ‘The more a study contains specific propositions, the more it will stay within feasible limits’ (p. 22);
- the need for a ‘chain of evidence’ to be established through the case study; and
- the role of theory development: ‘Theory development does not only facilitate the data collection phase of the ensuing case study. The appropriately developed theory also is the level at which the generalisation of the case study results will occur’ (p. 31).

## RESEARCH DESIGN

Rodwell and Woody (1994) assert that for constructivist inquiry:

... the mutual interaction of the inquirer and the respondents as well as the value base of the inquiry influence the preferred methodological strategies

and that such strategies include

... data collection in a natural setting and reliance on an emerging research design, with the human inquirer as the primary research instrument. Qualitative methods, particularly interviewing and participant observation, are chosen to allow a probing of the tacit, or intuitive knowledge of the respondent. Results are reported in a case study format with a focus on words rather than numerical data to provide a thick description of the phenomena under study. (p. 316)

A short course was scheduled to take place locally at the beginning of the research period, in October 1995. A research design that could be framed around the experiences of attending practitioners appeared both possible and potentially fruitful but was not without its drawbacks.

The *advantages* of constructing the fieldwork around the practitioners attending this event were:

- maximising the use of my own participant-observer position, as attendance at the training event was possible;
- minimising the risk that researcher and practitioners while talking about the same SFT approach might be talking about different forms<sup>151</sup> (although it is acknowledged that the SFT approach itself is still evolving);
- ensuring that access to ‘the field’ would be less problematic, as the course organiser and some of the course participants would be ex-colleagues of mine. My own credibility and trustworthiness in the eyes of the participants were strengthened by my recent working life as a colleague and practitioner. I could be seen to ‘know’ their world.

The prospective use of a particular cohort of practitioners all receiving training at the same time was also seen to offer some advantages:

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<sup>151</sup> I had been trained in the approach by the same trainer some years previously.

- by providing a large number of practitioners with varied lengths of experience, work settings, and orientations to practice who would all be exposed to the same training event;
- strengthening the co-operation of participants by notifying them of the research project at the time of the course
- improving the reliability of the source of data by prospective agreement with the course organisers that a detailed and accurate attendance list would be compiled.

Relying on the training course and its participants as the primary source of data also yielded some *drawbacks*:

- the extent to which I had been connected with the introduction of SFT through my organisation of earlier SFT training posed the risk that participants might be less likely to report negatively on their experiences or views and that the study would suffer from ‘response bias’ (Yin, 1994: 80);
- as a former working colleague of some of the participants and as a former user of the approach, it would be a challenge to create a suitable distance from the material to enable some conceptualisations and objective assessment to take place.

Both drawbacks were addressed explicitly in the research design: the first by the decision to interview the participants by telephone and by explicitly giving permission to the interviewees to ‘rubbish’ the approach; the second by adopting a research design which allowed data analysis to be completed after fieldwork had taken place, thus increasing the time distance since my transition from practitioner to academic.

#### **THE RESPECTIVE ROLES OF PRACTITIONER AND RESEARCHER**

Lang (1994), in considering both the similarities and the differences between the practitioner and the researcher, concludes that the social work profession ‘appears to have an imbalance between strategies that produce knowledge and those that direct action’ (p. 273). She suggests that combined researcher-practitioner initiatives focused on direct practice allow *‘both knowing and doing to be derived from the same data*’ (p. 274, my emphasis). Existing theory has a more provisional status, and ‘must be examined in terms of its relevance, scope, potency, adequacy and completeness’ (p. 276) so that theory can be generated inductively as well as applied deductively. Alliances between practitioners and academics can occur: ‘so that the practitioner carries the bottom level of observing, recording and first-level abstracting, while the academician works in the upper levels of abstraction, generalization, classification and conceptualization’ (p. 271).

Fook (2000) suggests that in theorising social work practice, research studies based on collaborative and participatory forms of inquiry ‘recognise that theories are often most effectively

generated from practice through an alliance and dialogue between researchers and practitioners' (Fook, 2000: 4). Stern (1994) highlights the responsibility placed on researchers who:

... must find ways to capture their (practitioners) wealth of knowledge accumulated from experience. For example, in-depth interviews with practitioners can involve them in knowledge-building activities without burdening them with the requirements of research methods. (p. 288)

My familiarity with the practice theory, and my closeness to and recent membership of the world which I was now investigating threw up both advantages and disadvantages as already outlined. The need to minimise the effects of my public association with the method led to a rather unusual method of data collection: that of in-depth telephone interviewing.

### **TELEPHONE INTERVIEWING**

While case studies are sometimes presumed to require long periods of immersion in the 'field', Yin (1994) has also noted that 'One could even do a valid and high-quality case study without leaving the library and the telephone, depending upon the topic being studied' (p. 11).

This study was unusual in that respect: the main body of fieldwork was conducted in the form of in-depth telephone interviewing, supplemented by documentary analysis.

The contemporary researcher should consider how the different modes (of interviewing) might be used in combination with the purpose of capitalising on the respective strengths of each mode and limiting the effects of their respective weaknesses. (Lavrakas, 1993: viii.)

Telephone interviewing has been a popular and widespread method of data collection in social research, particularly since the Second World War (Sarantakos, 1993: 196). Although commonplace in surveys and quantitative studies, it is less frequently used in qualitative research. Although cheaper than face to face interviewing surveys, it also has limitations:

... visual aids cannot be used to help put over question and anSocial Workerer categories; the interviewer is deprived of all the visual cues that give information on the respondent's reaction and also of the opportunity to communicate verbally by smiling, eye contact etc. Non-response is usually 5-10 % higher on telephone than on comparable face to face interviews. (Sarantakos, p. 156)

Sarantakos has listed the advantages and disadvantages of telephone interviewing, which when the use of randomised dialling and selection techniques are excluded (as not relevant to this design) include:

*Advantages:* produces quick results; allows the study of relatively large samples; is relatively economical; allows more open communication since the respondent is not confronted by the interviewer; reduces bias in that factors such as race, ethnicity, appearance and age do not influence the respondents; and offers more anonymity than other techniques.



*Limitations:* the risk of a high refusal; the exclusion of visual observation and contact; the difficulty of controlling totally interview conditions.

For this study, the advantages of telephone interviewing were seen to outweigh the limitations because of the psychological distance it offered which offset particular local factors in play: the public association of the researcher with the approach under examination; and the previous relationship of the researcher to some of the participants as colleagues.

Foddy (1993) discussing the effects that are likely when the interviewer is perceived by the respondent as a social equal, suggests that:

... psychological distance between the interviewer and the respondent can be increased by removing the physical presence of the interviewer from the interview from the research situation. This can be done by conducting interviews over the telephone. (p. 121)

The trade-off for the creation of this distance was the disadvantage of not having the benefit of the non-verbal cues which a face-to-face researcher can use, and not being in a position to fully control the conditions of the interview. This was a factor of some concern because of my knowledge of the busy and often crowded conditions in local social work offices. As the nature of the questions was qualitative and evaluative, this could have created a restraint on the respondent. It was therefore suggested both in the initial contact letter, and at the beginning of the telephone contact, that the interview could be conducted at the respondent's home telephone number if so wished. Several of the respondents exercised this option, but the majority chose to be interviewed at their place of work, often arranging a time when there would be privacy or less than usual activity in the workplace.

In this study, telephone interviewing was felt to lessen the risk that participants would report what they thought the researcher wanted to hear and it was thought more likely that participants would report negative impressions over the telephone than in a face-to-face interview. A telephone survey was also logistically simpler. Potential respondents were based in a total of 37 locations, including three outside Dublin. Face-to-face interviews would have consumed considerable time and expense.

The practice of making initial contact with a letter has been said to increase response rates and was used. Although a non-response rate of 10-15% has been reported for telephone surveys (Morton-Williams, 1993: 156), these refer to anonymous randomised surveys. No outright refusal to participate was expressed in my study. Respondents with whom direct telephone contact was not established, despite message-leaving and repeated attempts at contact, were treated as 'refusals'. Their number totalled 8 of the eligible 60 respondents, or 7.5%, a good deal lower than the figure quoted above.

The *length of time* for which it is possible to engage respondents in a telephone interview has also been a subject of debate. Although telephone interviewing was initially regarded as appropriate only for very short questionnaires, it has been found that 20-30 minute interviews are acceptable both for business and general population surveys. Findings both in the United States and in Britain, based on large-scale studies, indicate that differences between answers given in telephone and face-to-face interviews are small (Groves & Kahn, 1979; Sykes & Collins, 1987). Respondents tend to give briefer answers to open questions on the telephone and there are said to be ‘some mode effects on answers to sensitive questions’ (Morton-Williams, 1993: 157), which primarily indicate that people are less likely to give socially acceptable answers to questions concerned with social prejudice, but are reluctant to share more personal information such as personal finances. As there is no literature relating to smaller-scale, local surveys where the interviewer and respondent belong to the same local professional groupings and are known to each other, the implications of these findings for this study can only be speculative.

Royse (1995) suggests that the question of *relevance* of the topic to the interviewee is probably a significant factor in telephone interviewing:

As a general rule, the more interesting the topic is for the respondent, the greater the probability that the respondent will complete the interview even if it is lengthy. (p. 152)

In this study, interviews varied tremendously in length from about 15 minutes in the handful of cases where practitioners had not engaged with either the approach or the training and had little to say about either, to over 60 minutes for those who were more engaged in discussing and reflecting on their practice. The majority of the interviews lasted for between 30-45 minutes. In line with Morton-Williams’ (1993) findings that ‘much refusal to participate arises because the time at which the approach is made is inconvenient’ (p. 166), many of the initial contacts did not result in an interview at that point but a scheduled one at a later date. In retrospect, I feel it would have improved the quality of the study if a ‘fall back’ set of questions had been devised to anticipate the non-engagement of some of the respondents with the specific SFT content. This would have enabled me to track in greater detail the theorising processes of those workers who had not engaged with SFT.

The interviews were timed to take place at least a year after the training event. This decision was based on my existing knowledge on salience of events and memory recall, my interest in the longer-term as opposed to immediate effects of innovation introduction and in the impact of environmental factors in the transfer process.

## **ADVANCE CONTACT OF RESPONDENTS**

A potential respondent will be more readily persuaded to participate if he or she has been 'warmed up' by advance notification of the survey than if he or she merely receives a 'cold call' from an interviewer without any advance warning. (Lavrakas, 1996: 122).

The potential respondents were alerted to the research project at several stages:

- (a) during the training event, by personal address and announcement, in Oct. 1995;
- (b) by personal letter to the workplace in September 1996; and
- (c) by follow-up phone calls to arrange telephone interviews in the period October 1996-March 1997.

## **INTERVIEW SCHEDULE DESIGN**

Qualitative researchers are said to be 'interested in people's interpretations of objects and events ... including definitions' (Sarantakos, 1993: 113). Questions which were open-ended and elicited the views of the interviewees were selected over those that were directive or framed in a way which would invite agreement or disagreement with the perceived position of the interviewer.

The semi-structured questionnaire used as a guide for the interviews following a simple sequence from motivation to attend the course, through experience of the short course, understanding of the SFT approach, views on its relevance to social work generally and their work specifically, to intentions at the end of the course through their actual experimentation and adoption and their views on what helped and hindered their progress (Interview schedule, Appendix B).

While the 'trigger' questions on the schedule formed the basis for each interview, my style of interviewing could be said to have been 'creative' allowing for 'complex relationships between sociological, psychological and linguistic variables' (Foddy, 1993: xi).

A lead-in section, where information was given on the purpose of the interview, (and reassurance given that 'testing' of knowledge was not a focus) was included on the basis that 'respondents who know why a question is being asked are in a better position to help a researcher than those who don't' (Foddy, 1993: 72). The 'lead in' on this interview schedule was also seen as important to stimulate respondent recall.

Foddy (1993), in reviewing some of the literature concerned with the limitations of human memory, indicates that a difference exists between available recall of intentional and unintentional behaviours, with the former the most available for recall. Foddy has concluded that:

... forgetting is related to elapsed time, salience (defined as unusualness; associated high economic or social costs or rewards; and continuing consequences) and the number of events that compete with the particular event(s) that the respondent is asked to remember. (Foddy, 1993: 93)

Memory for salient events has been found to be satisfactory for up to one year.

The recommendation that researchers should refer to key events in the same terms that the respondents would have used when they were encoded was also followed, and resulted in the precise wording of the lead-in, naming the training, the place and presenter and dates as 'cues' to trigger memory.

### **PILOT STUDY**

The interview schedule went through various formats in design, following initial piloting and refinement of the central research questions. The pilot study was used in this case to establish the following:

1. Did the questions make sense to the respondents?
2. Did the questions elicit the information that I wanted?
3. What length of time was needed for respondents to consider and reply to each question?

Two pilot interviews were conducted on a first interview schedule, using two social work practitioners who had attended the training but had subsequently left social work practice. Following these pilots, the interview schedule was refined by adjusting some questions.

### **RECORDING OF DATA**

The data was recorded in two ways:

- (i) an interview schedule was used as a guide to the areas to be covered; the initial data on the profile of the individual was recorded here, as were some key points in the relevant sections;
- (ii) the interviews were also tape-recorded. Permission for this was sought from the respondent at the start of the interview. In considering how to ensure that respondents' consent to participation in the research was both informed and ethical, they were assured that they would not be identifiable although direct quotations might be used from the interviews which they would recognise themselves. They were also notified that the primary purpose of the research was the completion of a postgraduate thesis and that if materials were developed from the research for subsequent publications, care would be taken to ensure anonymity in relation to specific comments and quotations.

The dual recording by tape and written notes had several advantages: as the approach was essentially qualitative in nature, it was important that accurate recording of the interview should take place, which would provide not only the 'hard' data in the form of the specific content, but which would also allow a review of the process of the interview and the 'softer' data in the form of

the subtle nuances, pauses and changes in tone and affect which provide the context within which the communication needs to be understood.

Sarantakos (1993) has indicated the errors in written recording of data that can occur. These are associated with selective hearing or vision; misunderstanding of the respondent; too-early or too-late registration of the responses, and incomplete, illegible or faulty responses. The use of a taped backup would, it was hoped, eliminate most of these.

All 52 respondents agreed without hesitation or questions to the taping of the interview which in retrospect appears to have been quite an achievement. It is possible that the 'invisibility' of the taping equipment (at the other end of the telephone line) was an advantage in this respect. None of the respondents asked for the tape-machine to be turned off for any section of the interviews which has been reported in other studies (DHSS, 1978).

Equipment failure occurred in 3 cases where the taping mechanism attached to the phone failed. In these cases, the written notes that had been taken as a back-up proved invaluable. In 5 other interviews the quality of the tapes was poor, where the respondent spoke in particularly low tones and the precise conversation was difficult to deduce. In these cases the completed interview schedules in combination with exhaustive listening of the tapes enabled satisfactory transcripts to be developed.

In common with other researchers (DHSS, 1978), I found that as I became more skilled in tuning into the interviewees, I also became more proficient at probing and eliciting detailed responses from respondents, and also more adept at dealing with a range of responses.

#### **ANALYSIS OF DATA**

Compared to the relative simplicity of the early stages of structuring the broad parameters of this study (identifying the central questions of this study, deciding on a research design and data collection site and constructing data collection instruments) and carrying out the fieldwork itself, the latter stages of analysis, interpretation and final theorising were both more lengthy and complex than I had envisaged. The amount of generated data collected through the interviews was vast, and was supplemented by documentary and theoretical material available both on the field of social work and the particular local context as outlined in earlier chapters.

The interview data was first fully transcribed by myself as individual reports. While slow, the length of time it took was more than compensated by the depth of familiarity it gave me with the data. It was then possible to analyse one by one the progress of respondents from first knowledge of the innovation, through to the short course, their 'reading' of the approach, their intentions at the

end of the short course, their subsequent experiences of transferring the innovation back to practice and their descriptions of and reflections on both the innovation and the innovation-introduction process.

In the early stages of data analysis, spread sheets were devised to draw up an initial profile of the cohort of respondents, detailing both hard data and a surface impression of qualitative data relating to levels of engagement and experimentation with the practice innovation.

The process of immersion in the data followed. Colour codings were manually used on the transcripts to highlight what initially appeared to be particular differences and similarities and also to assist analytic memo-writing as underlying themes and patterns began to emerge. Movement from the data back to the literature, searches for additional theoretical tools of analysis and frameworks with which to both compare and make sense of the data and also interrogate it continued for some time.

#### **INTERPRETATION OF THE DATA**

Drawing on the work by Miles and Huberman (1984: 216), I used the following tactics and principles to draw meaning from the data:

- *Counting* – Important, significant or recurrent themes were identified and counted. Counting is important to help identify trends, verify assumptions and protect against bias. In the findings chapters for example, one theme of significance which emerged was that of the appeal of the approach and the different interpretations or ‘readings’ evident. These were elucidated and also counted to enable readers to assess the veracity of this theme.
- *Patterns* and themes were noted and examined. One example of this carried out early in the analysis was noting the importance of the pre-course context, motivations for attending and the relationship of this to adoption patterns, separate from work environment post-course. Pattern recognition in general took the form of ‘content analysis’, for example where data relating to the appeal of the innovation was scrutinised, categorised and then developed into main themes; and ‘thematic analysis’ where recurrent patterns relating to the engagement of respondents with the innovation were identified and tracked. Initial categories were developed, tested and refined as necessary. For example, I assumed initially that I could interpret respondents’ level of engagement with the innovation, but then found I had to more accurately accommodate the large number of respondents who had made no definitive decision to adopt or reject SFT.
- *Assuring plausibility* – conclusions drawn must make sense, fit into the logic and research principles and be plausible. As Fook (2000)<sup>152</sup> suggests, the combination of a deductive and

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<sup>152</sup> ‘Deductive methods involve the application of pre-existing frameworks to the data, whereas inductive approaches involve a development of theory from the data itself...in an inclusionary framework, I would

inductive approach to analysis, in my experience, both enhanced the rigour of this study and also ensured that there was a reflexivity to the theory generated. The use of Rogers' diffusion innovation theory alongside theories of individual learning and the development of professional expertise enabled me to initially map out some tentative findings relating to specific theories. Once the data was ordered according to these theories, the limitations of the theories became evident and pointed to the need for a more inductive analysis of the data, concentrating particularly on the variables which had appeared superfluous at first. It was precisely in the identification of the seemingly extraneous and less tangible variables (such as levels of confidence and hope and the differing conceptualisations of the social work role) and the realisation that existing theories could not accommodate these, that an in-depth inductive analysis became a compelling necessity.

- *Clustering* – events, sites, actors and processes that have similar patterns or characteristics are sorted into categories and grouped together. Different types of categories were necessary in this study: firstly between those from different settings; and from different locations within the one setting; secondly, between those who were already using the practice innovation and the 'newcomers'; thirdly between newly qualified and more experienced practitioners; fourthly between practitioners and managers; and fifthly between those who successfully adopted, those who rejected and those who were undecided. The generation of these categories enabled me to analyse and describe the data in a form which respected and acknowledged the differing experiences and perspectives of respondents as opposed to conflating their similarities while denying their differences.
- *Subsuming particulars into general*: encouraging the development of conclusions when the researcher relates empirical data to general concepts and categories and
- *Building a logical chain of evidence* allowing interpretations to be made were both assisted by theoretical triangulation as already outlined. By presenting the empirical findings as a temporal or historical narrative, commencing with the 'arrival' of the practice innovation to the local context and tracking the respondents through the different phases of their experiences, I also aimed to build a logical chain of evidence.
- *Making conceptual and theoretical coherence*: by means of analysing and categorising data and interrelating variables, moving from data to constructs to theories is most evident in Chapter Eleven where the findings are discussed and made sense of through the development of a synthesis of explanation from differing theoretical fields.

## **ETHICAL CONSIDERATIONS**

Royse (1995) notes that guidelines to protect research subjects developed after the Nuremberg Trials on World War Two, where the ethics of Nazi medical experiments on involuntary prisoners

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suggest that both types of analysis are necessary ... frontline practice can be understood or theorised in both broad ways.' (Fook, 2000: 8)

was addressed. The resulting deliberations culminated in the development of the Nuremberg Code, ‘a set of ethical standards by which research with human subjects can be judged’ (p. 304). National, occupational and institutional codes of ethics have followed, in some cases copper-fastened by legislation and ethics boards; in others left to the good faith of individual researchers, and/or academic regulation to conform to good practice.

In the absence of dedicated guidelines for ethical research in the Irish social work context, Royse’s (1995: 309-311) guidelines were adopted as an appropriate map:

**‘Guideline One – Research subjects must be volunteers’ (p. 309)**

In this study no attempts were made to force or ‘encourage’ participation through organisational channels. Consent had been given by the commissioning agency (via the short course organiser) for the research study to be conducted, and this information was transmitted to potential respondents. Each participant was initially approached individually by letter for agreement to be interviewed (Appendix B). Those who did not respond to invitations to participate or who were unavailable by telephone were deemed to be ‘refusals’ and their right to make that decision fully accepted.

**‘Guideline Two – Potential research subjects should be given sufficient information about the study to determine any possible risks or discomforts as well as benefits’ (p. 309)**

“Sufficient information” includes an explanation of the purpose of the research, the expected duration of the subject’s participation, the procedures to be followed, and the identification of those procedures that might be experimental’ (Royse, pp. 309-10). Appendix B contains the ‘advance’ letter sent to potential respondents giving a simple statement of the purpose and status of the study. In addition at an early stage of the initial telephone contact (after confirming identity and obtaining some factual data) the purpose of the interview was explained more fully<sup>153</sup> and respondents asked if they had any objections to the focus of the interview. Potential subjects were therefore invited to ask more questions about the study if they so wished. Many asked more questions at the end of the interview and expressed support for the project at that stage.

**‘Guideline Three – No harm shall result as a consequence of participation in the research’ (p. 310)**

Royse notes that while for most social work research studies, resulting harm is unlikely, nonetheless ‘Subjects should not go away from a study with a feeling of lowered self-esteem or sense of self-worth, or that they possess undesirable traits’ (p. 311). While a conscious effort was made to emphasise the importance of *their* judgements as to the relevance of SFT to practice, it is possible that some non-adopters of the approach may have felt less valued than adopters. Mindful of both ‘pro-innovation bias’ (Rogers, 1995), and keen to establish what structural and individual factors came into play in the innovation-decision process, I attempted to remain neutral in

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<sup>153</sup> including the fact that it was for a research thesis and not a commissioned piece of research; that participants would not be identified by location or name in any subsequent publications or presentations.



exploring respondents' reasons for non-adoption as well as for adoption. I attempted to convey my position that whilst an advocate of SFT, I believe there are 'many ways to skin a cat' as Howe (1987:1) has memorably noted in relation to social workers' use of theory.

Most participants indicated that they had enjoyed the interviews, and found them useful as an exercise in reviewing their assessment of SFT.

This research study did not promise or lead to any improved training opportunities or development of SFT support networks for practitioners, and in this I may have disappointed the participants. In retrospect there may have been opportunities to provide more<sup>154</sup> systematic feedback to the research participants which could have strengthened their case for further SFT training and support.

**'Guideline Four: Sensitive information should be protected' (p. 311)**

The privacy of respondents has been maintained by the anonymising of direct quotes and the reporting of information in the aggregate. The exceptions are some case examples where workers might be identified by colleagues through case details. While the detail given is required for the purposes of this thesis, alterations will be made if material were developed for publication.

The ethical consideration that I remained most conscious of throughout the research process was that of the need to do justice to the participants in this study and their sharing of frontline practice experiences with me. Without their willing participation and generosity of time and reflection, this study would not have been possible. No ethical dilemmas arose during the fieldwork period regarding client safety or practitioner liability. Any client names mentioned have been altered.

**CONCLUSION**

This exploratory and explanatory study into practitioners' engagement with a practice innovation in the post-qualifying context takes the form of a case study, as 'an intensive investigation of a single unit' (Gilgun, 1994a: 371). It involves the examination of multiple variables and the interaction of the process studied with its context.

As a single case study, it is idiographic<sup>155</sup> in nature and therefore the findings and conclusions drawn are tentative and subject to revision.

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<sup>154</sup> Feedback about the main findings were provided to the course organiser, and latterly to the first training officer in the local health board in 1998, when another SFT initiative was proposed but for a combination of reasons did not proceed.

<sup>155</sup> *Idiographic*, meaning a single unit is studied, multiple variables are investigated, and generalizing is analytic rather than statistical and probabilistic' (Gilgun, 1994: 372).

My approach to theory-building is both deductive and inductive, combining theoretical triangulation with the generation of new insights from the empirical data.

In seeking to accommodate both the influence of local conditions and powerful social systems with the subjective meaning-making processes adopted by individuals, a combined constructivist/constructionist philosophy underpins the orientation of this study.

## CHAPTER SEVEN: CROSS-NATIONAL DIFFUSION

### SFT: FROM AMERICAN FAMILY THERAPY TO IRISH SOCIAL WORK

The processes whereby SFT was introduced into Irish social work during a certain period can be studied, drawing on the literature on the Diffusion of Innovation (Rogers, 1995). While I cannot claim that *all* processes that occurred are covered, it has been possible to identify significant events in the cross-national diffusion.

### THE INNOVATION DEVELOPMENT PROCESS

... consists of all the decisions and activities, and their impacts, that occur from recognition of a need or a problem, through research, development, and commercialization of an innovation, through diffusion and adoption of the innovation by users, to its consequences. (Rogers, 1995: 132)

#### Stages in the Process

##### *(i) The identification of a need*

... stimulates research and development activities designed to create an innovation to solve the identified problem or need. SFT, as described in the literature review, developed as a new technology<sup>156</sup> in the field of family therapy through the ecosystemic epistemology<sup>157</sup> adopted by de Shazer (1982). The ‘problem or need’, which de Shazer and the Milwaukee team set out to research was to develop the most effective and efficient way of doing therapy.

##### *(ii) The use of applied research*

While de Shazer was researching clinical practice<sup>158</sup> from 1982 and was clearly intent on developing his own particular brand of therapy (de Shazer, 1982, 1985)<sup>159</sup>, it was through a process of applied research that SFT was developed<sup>160</sup>. de Shazer has described how it was through watching live and taped therapy sessions that he came to formulate his approach, based on what appeared to work (de Shazer, 1985, 1988). As Rogers has noted,

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<sup>156</sup> A new technology is ‘a design for instrumental action that reduces the uncertainty in the cause-effect relationship involved in achieving a desired outcome’ (Rogers, 1995, p. 134).

<sup>157</sup> ‘Once the description of therapy includes the therapist’s system and the family system, a new suprasystem needs to be considered. This way of thinking, knowing and deciding is called an *ecosystemic epistemology*’. (de Shazer, 1982, p.2).

<sup>158</sup> Both his own and that of other therapists at the Brief Family Therapy Center in Milwaukee, Wisconsin.

<sup>159</sup> ‘Since 1982, my colleagues and I have been struggling with presenting our ideas in useful ways as we continue to work out the implications and ramifications of those ideas in our work with clients’ (de Shazer, 1991, p. xiii).

<sup>160</sup> ‘It is our work with clients, of course, that continuously leads to our having to find new ways to describe what we and clients do and new ways to analyze the clinical situation’ (de Shazer, 1991, p. xiii)

Not all innovations come from research and development ... they may instead arise from practice as certain practitioners seek new solutions to their problems/needs. (Rogers, 1995: 143)

This process in relation to SFT has been documented fully elsewhere (Miller, 1997). The development of the solution-focused aspect of the approach was to a certain extent serendipitous, following from an accidental realisation that, within the prevailing strategic brief therapy approach, the use of compliments and a positive focus led to the development of co-operative relationships with clients and increased possibilities of change. While building on existing wisdom within the family therapy field, de Shazer and Berg 'invented' SFT by developing a different way of doing therapy, which centred on the reframing of therapy as a joint endeavour between therapist and client to identify and use solution-focused patterns of thinking and behaving. That the approach was developed from research on practice-centred on reviewing tapes and live therapy sessions incorporating existing 'expert' practice in day-to-day situations with a range of families and problems and grounded in practice realities – gives it a great deal of professional credibility.

### ***(iii) The Development of an Innovation***

Development of an innovation is the process of putting a new idea in a form that is expected to meet the needs of an audience of potential adopters. (Rogers, 1995: 137)

In the arena of industrial and scientific research, inventions are claimed and protected by the patenting process, which guards the rights of the inventor during the period in which the new idea is commercialised. No such protection exists in the field of therapy, but a form of intellectual ownership can be claimed by the publication of new ideas and approaches in peer-reviewed and respected journals. The publication of the article: 'Brief Therapy: Focused Solution Development' (de Shazer *et al.*, 1986) in a prestigious peer-reviewed international family therapy journal (*Family Process*) can be viewed as an attempt to claim intellectual ownership, or at least, originator status for the solution-focused approach. The connection was deliberately made between SFT and the earlier MRI model of Brief Therapy in the title of the paper. Publication in *Family Process* ensured that de Shazer's original target audience (American family therapists) was reached and that this new brand of therapy would be of interest.

### ***(iv) The Commercialisation of an Innovation***

... is the production, manufacturing, packaging, marketing and distribution of a product that embodies an innovation. (Rogers, 1995: 143)

From an analysis of the history of the introduction and diffusion of SFT initially into the field of family therapy and then into related helping arenas, several factors can be distinguished which contributed to the commercialisation of the innovation:

- packaging the approach as 'brief'<sup>161</sup> and simple to maximise its appeal;

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<sup>161</sup> Although as will be noted by the title of this thesis and some of the literature referred to, 'Brief' has been dropped by many theorists and practitioners, including de Shazer (see Miller & de Shazer, 1998).

- acceptance of the approach by some near- peers;
- adoption by the originators of a training role;
- production of materials in the form of training literature, theoretical texts, video and audio tapes which could be marketed and distributed;
- identification and support of key actors within various fields, local figures of significance, who would ensure the wider diffusion of the innovation;
- use of both mass media and interpersonal channels of communication;
- alliance with others who advocated similar approaches, in the form of ‘technology clusters’ (Rogers, 1995: 143)<sup>162</sup>. As one of the social constructionist approaches, de Shazer’s work has also been publicised in association with that of Bill O’Hanlon’s ‘possibility therapy’ and Michael White’s ‘narrative therapy’ (Hoyt, 1994, Corey, 1996) although de Shazer has rejected the linkage made between SFT and Narrative therapy.<sup>163</sup> Tracer studies into the innovation-development process generally show that major technological advances require not just one innovation but a cluster of innovations, and that ‘we should not forget this functional interdependence of innovations’ (p. 155) a point which can be overlooked if investigations of single innovation are undertaken as if they were completely independent.

#### ***(v) Diffusion of the Innovation***

Mass media events are often the most rapid and effective means to inform an audience of potential adopters about the existence of an innovation, that is, to create awareness-knowledge. On the other hand, interpersonal channels are more effective in persuading an individual to accept a new idea. (Rogers, 1995: 18).

The diffusion of the practice innovation – SFT – from a family therapy centre in the USA to Irish social work during the period 1986-1996 occurred through a combination of events involving both mass media channels and interpersonal channels. The first level: the creation of *awareness-knowledge*, was achieved primarily through the use of mass media channels and the creation of local and international networks as outlined in the accompanying Timeline chart (Table 7a). The main events are distinguishable as:

- The publication of the first article in an internationally respected family therapy journal introducing the practice innovation (de Shazer *et al.*, 1986);
- Subsequent international conferences in the USA since 1986, attended by, amongst others, British and Irish family therapists. Conference papers on the emerging SFT approach created ‘awareness-knowledge’ (Rogers, 1995: 18) and informal networks among

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<sup>162</sup> Technology clusters are two or more innovations which are packaged together in order to facilitate their diffusion because they have a functional interrelatedness, or at least are perceived as having so by potential adopters.

<sup>163</sup> De Shazer maintains that the two are distinct in terms of philosophical roots; White maintains that narrative therapy is distinct in its political roots and emphasis placed on the social and political in its analysis of personhood. (Gilligan & Price, 1993).

professionals peers attending such conferences contributed to the process of gathering interest and persuasion.

- The first visit to the British Isles by de Shazer and Berg, originators of the approach took place in the spring of 1990 when they presented their innovation to their professional peers. This conference was hosted by the Brief Therapy Project, then part of the Marlborough Family Service in London.
- The first British publication on the approach in May 1990, demonstrating its application and use by a social work team in a London family therapy setting (George *et al.*, 1990).
- The establishment of the first training courses in SFT in the British Isles in January, 1991, set up by the Brief Therapy practice in London.
- The establishment of the first British clinic devoted to the use of the approach in London in 1993 by former members of the Brief Therapy Project.
- The establishment of EBTA – the European Brief Therapy Association in Paris in September, 1993, attended by brief therapists from five countries, including the London innovators.
- The first EBTA conference in Brugge in March 1994 attended by teams from 13 different European countries which marked ‘the first step towards channelling innovation within brief therapy in Europe’ (Hawkes, Wilgosh & Marsh, 1994: 19)

Figure 4: Timeline: Some key events and dates in the cross-national diffusion of SFT

Since 1994, the continued diffusion of the innovation in the European/Irish context<sup>164</sup> has taken place through publications, conferences, workshops and training activities by key players including firstly American innovators and adapters (de Shazer, Berg & Bill O’Hanlon); secondly, the European early adopters (Iveson and colleagues of the Brief Therapy Practice of London; Luc Isebaert of the Adult Psychiatric Services in Brugge, Belgium; Beyerbach, Carranza and colleagues at the Depto. Terapiafamiliar in Salamanca, Spain, and Alastair McDonald of the Adult Psychiatry Service in Carlisle, England, amongst others); and thirdly in the Irish context, through the social work education programmes in all three universities<sup>165</sup>, the training work of Walsh and Loughran, and since 1998, Sharry and colleagues at the Dublin-based Brief Therapy Centre now the most proactive proponents of SFT in Ireland.

It was therefore through a combination of professional journals, publications, associations, conferences and training workshops involving international networking that SFT first became diffused beyond the American family therapy network into the European context. On this level, it remained initially within the field of ‘therapy’, attracting the attention of brief therapists across a range of settings and professions (psychiatrists, psychologists, nurses, teachers and social workers) all of whom adopted the mantle of therapist as evidenced by their subscription to professional therapy journals and associations, and attendance at professional therapy conferences.

The diffusion of the approach to the social work context within the British Isles was led by some key individuals who straddled the worlds of therapy and social work, practising therapists who were professionally social work trained and who had, so to speak, a foot in each camp.

#### **THE SPECIFIC ROLE OF THE BRIEF THERAPY PRACTICE (LONDON)**

The social work team at the Marlborough Family Service in London, consisting of Chris Iveson, Evan George and Harvey Ratner became early innovators, when:

Late in 1988 we each found ourselves moving in a similar direction ... interested in de Shazer’s work. Early in 1989 we decided to spend a year applying de Shazer’s model to the whole range of clients coming to the Marlborough and set aside one afternoon a week to work together as a team. (George *et al.*, 1990: 1)

They formalised their experimentation with the establishment of the Brief Therapy Project within the Marlborough and were later that year in 1989 joined by two female colleagues. This initial project was essentially a ‘skunkworks’ – described by Rogers (1995) as

... small and often subversive units within a large organization that pioneer in creating innovation ... an especially enriched environment that is designed to help a small group of individuals escape usual organizational procedures so that innovation is encouraged. (p. 139)

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<sup>164</sup> There have also been developments in other parts of the world, e.g.: in Australia (Turnell & Edwards).

<sup>165</sup> University College Dublin; Trinity College Dublin and University College Cork.



Skunkworks are seen as particularly important because the usual bureaucratic structure of organisations can be resistant to innovation. This was certainly so in this case: the Marlborough Family Service – a prestigious and influential family therapy centre in London, headed by a consultant psychiatrist, who was an established figure in the family therapy field, withdrew all support for the Project two years later, and refused to allow subsequent training programmes organised by the Project to be held under the auspices of the Marlborough. The innovation was resisted even more actively in later years when the powerful London Institute of Family Therapy refused to continue employing members of the Project as tutors on their clinical family therapy training (although this decision was later reversed as the popularity of SFT became evident) (Iveson, personal communication).

It is worth noting the extent to which the innovation appeared to threaten the established orthodoxy of family therapy in the UK.

The Project members subsequently formed the Brief Therapy Press and in 1990 published the first British text on the approach (George *et al.*, 1990). Following the removal of agency approval for the approach, the members established their own practice centre in 1993. The centre remains a pivotal focus for training, conferences, publications and networking among the advocates and potential adopters of BSFT in the British Isles, but is now regrettably located outside the public health and social services field.

#### **DIFFUSION FROM THE UK TO IRELAND**

Four of the main actors involved in the promotion of SFT in Ireland in the 1990s trained with the Brief Therapy Practice in London, for varying lengths of time between 1990 and 1997. Having become early adopters, these four actors moved into positions as '*product champions*'<sup>166</sup> who not only adopted the new approach but also took up the cause of spreading the message to others (Smale, 1998). The reasons why they made this move have not been empirically established. However, through the processes involved for me, as one of the actors; and through observations of others, I can speculate that the benefits that accrued to us as 'product champions' included professional and academic status and credibility; financial rewards and potential networking ability. For two of us, located within the academic field, championing the approach led to closer links with the world of practitioners, status within our own institutions as trainers who were valued by professional agencies, material for publications and conference papers, and links with international figures within the SFT domain; and finally the excitement of being an innovator.

Other key figures of influence in the early diffusion process in Ireland, who did not take such a direct training role but who facilitated the dissemination of the approach were:

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<sup>166</sup> 'Product champions' are crucial early adopters, being the people who not only adopt new methods ,but take up the cause of spreading the message to others' (Smale, 1998: 110).

- an influential figure of international stature within the family therapy field, who straddled the worlds of social work academia and family therapy practice who had become familiar with the approach through personal contacts within the international family therapy network over the previous two decades; and
- a senior social work manager who had become familiar with the approach through informal networking with colleagues in Canada.

Both of these, but especially the first, can be considered as ‘opinion leaders’ whose backing gave credibility and status to the fledgling ‘product champions’; the second also acted as a ‘minder’ who sponsored and protected experimentation with the innovation in one of the health board area settings and who supported early adopters when the “going got tough” (Smale, 1998).

News of the innovation also filtered into the Irish social work setting through student placements abroad – both in North America and the UK; practitioners who moved to Ireland to work, and practitioners with links with colleagues in other countries. None of these, in themselves, are known to have led directly to the promotion of SFT in the Irish context, but these actors with early knowledge of the innovation may nonetheless have had an influence on near-peers through their positive evaluation of the approach.

#### **THE FIRST IRISH MASS MEDIA EVENT**

The first Irish SFT event for social workers in 1994 evolved from a case presentation undertaken by one product champions to her health board team, illustrating how it was been used successfully in the same work context. The social work manager for the area, who attended this presentation, became sufficiently persuaded that this was of potential use to become a ‘product champion’ within the organisation and became active in disseminating information about the approach within the wider organisational context. The manager was also a *Legitimate Initiator* – accepted by peers and professional colleagues as being entitled to introduce change. While the organisational culture and conditions in health board social work at the time (the smallness of the world and the flattened hierarchy which kept managers close to practitioners) probably lessened the risk of senior managers rejecting bottoms-up initiatives, this support from a legitimate initiator was necessary for funding to be secured to introduce the innovation to health board workers and others on a wider scale. Through the social work management group, funding was sought and granted and approval given for a designated number of social workers from each community care area to attend<sup>167</sup>.

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<sup>167</sup> A further small number of places were made available to practitioners from outside agencies, both to subsidise the cost and to promote interagency ‘goodwill’. The resulting cross-agency networking that was promoted became of significance in the continued diffusion of the innovation.

## IMPACT OF THE FIRST HEALTH BOARD INITIATIVE

No systematic evaluation was carried out following the two-day 1994 event, beyond the use of end-of training, so called 'happy sheets' (Horwarth & Morrison, 1999), which merely indicated that the training had been well received and that a number of participants were keen to develop its use in practice. These participants can be said to have moved from awareness-knowledge through to persuasion and a (provisional) decision to adopt it in their own practice. As will become evident however, this is only one step on the long road towards full adoption of an innovation, and could be more accurately described as a *conditional* decision to experiment with the innovation in practice.

In the absence of a formal organisational training and development structure, follow-up for the initiative remained the responsibility of the social workers at local level, and depended on the continued activities of the product champions, and informal networking between potential adopters.

Several developments took place in the period March 1994-October 1995:

- (i) A practice group throughout the Health Board was set up at the suggestion of the area manager who acted as a 'legitimate initiator' and an invitation was extended to those who had attended the March 1994 training to meet together to support each other in using the approach in practice.
- (ii) Several smaller locally-based groups of practitioners within the different health board areas, began to meet to support each other in the use of SFT in practice.
- (iii) One local area decided to send some of its workers to a training event in Dublin run by another group of UK based practitioners to reinforce the introduction of the innovation into that office.

While none of these individual developments were sustained, interest in SFT continued to grow and requests for further training were made, fuelled by 'news' of the innovation from new members of staff, students leaving college, and from those who had either studied or worked abroad. The product champion/ legitimate initiator, with support again from the management group, decided to run another training initiative in Oct. 1995, which provides the cohort of potential and early adopters who were interviewed for this study.

## **CONCLUSION**

Development of an innovation is only the first step in a process. The willingness of innovators to take an active step in the dissemination of their 'invention' is also important. Publication in peer-reviewed journals confers a certain status on new approaches in therapy. International conferences allow for the exchange of ideas within a community of therapists across national boundaries. The existence or creation of networks allows for more inter-active forms of persuasion to occur. Product champions play a part in the persuasion of others in their local networks in the early stages of the diffusion of an innovation.

## CHAPTER EIGHT: 'THE DUBLIN COURSE' – THE PARTICIPANTS

### INTRODUCTION

The SFT short course held in October 1995 attracted a cohort of practitioners and managers from the EHB region, some of whom were already *early adopters*; the others were *potential adopters* attracted by 'news' of the innovation. The 1995 course was the second of two large-scale events run by Chris Iveson of the Brief Therapy Practice in London for Eastern Health Board social workers in Dublin.<sup>168</sup>

Rogers' model for the innovation-decision process, as outlined at the end of Chapter Five,<sup>169</sup> is used here as a tool for the organisation and analysis of the data gathered. It is, however, adapted to allow for two differences that emerged:

- a) The 'prior conditions' category is expanded to allow for the distinction between sub-categories that emerged in this study<sup>170</sup>; and
- b) The original stages in Rogers' model<sup>171</sup> are adapted, as the data which emerged from this study suggest that the stages of persuasion/decision-making can be collapsed into one, as there is evidence that some individuals moved backwards and forwards between these stages over time, and can best be described as *undecided* or not persuaded at particular points. The adapted model now consists of four stages, and two possible exits from the process, either at Stage Two or at Stage Three:

Stage One: *Knowledge-seeking*, leading to either rejection/abandonment **or**

Stage Two: *Initial persuasion/decision*, resulting in either rejection/ abandonment **or**

Stage Three: *Experimentation and review*, resulting in either rejection/ abandonment **or**

Stage Four: *Adoption and implementation*, also subject to review at a later point in time.

These stages map out different points in the process. Some features, however, regarding the reformulated model need to be borne in mind:

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<sup>168</sup> The first training event had taken place in March 1994, attended by over 50 social workers. There had been no systematic evaluation of this initiative, but it had generated sufficient interest in the SFT approach for the course organiser to obtain funding for this second extended 4 day course.

<sup>169</sup> 'The innovation-decision process is the process through which an individual passes (1) from first knowledge of an innovation, (2) to forming an attitude towards the innovation, (3) to a decision to adopt or reject, (4) to implementation of the new idea, and (5) to confirmation of this decision. This process consists of a series of actions and choices over time through which an individual ... evaluates a new idea and decides whether or not to incorporate the innovation into ongoing practice' (Rogers, 1995: 161).

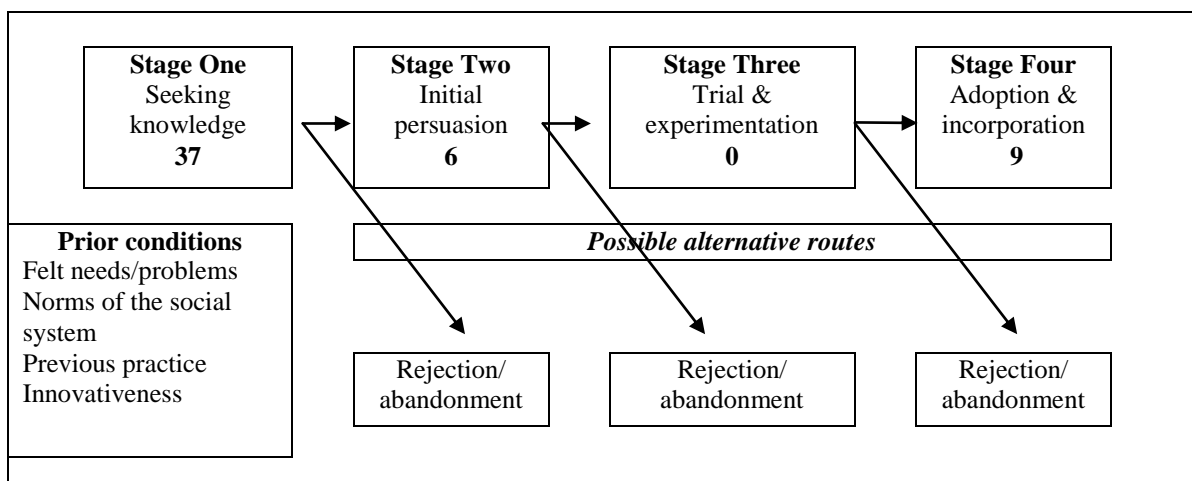
<sup>170</sup> For example, the category of 'felt needs/problems' now consists of three sub-categories: disappointment with traditional methods; need for brief approaches; and stuck/chronic cases.

<sup>171</sup> Knowledge; Persuasion; Decision; Implementation; Confirmation (Rogers, 1995: 163)

- The stages are not necessarily linear: for example, the data will reveal that initially seeking knowledge (Stage One) does not preclude individuals at further points along the process from continuing to seek knowledge<sup>172</sup>, perhaps of a different kind.
- In this adapted model, it is possible to opt out of the innovation-decision process after any stage, but this is not necessarily a permanent decision. Those who ‘exit’ at particular points in the process may review their decision in the light of new knowledge about the innovation, or changes in need, peer-acceptance or organisational support, at some future point in time.
- Similarly, adoption of an innovation and incorporation into personal knowledge and practice is not necessarily a permanent decision, and may be ‘updated’ by adoption of other innovations at future points in time.

The use of this adapted model allows for the mapping of the movement of respondents from the initial decision to attend the training course through to their positions in relation to use of the approach at the time of interview.

Figure 5: Location of respondents in the Innovation-Decision Process at the time of the SFT course (after Rogers, 1995)



### THE DUBLIN COURSE

- It was primarily aimed at social workers employed by the local health board. An internal circular was distributed advertising the course. A small number of places (15) were also made available to non-health board social workers in the region.

<sup>172</sup> The initial Stage One of seeking knowledge is primarily concerned with the development of *awareness knowledge* following on (or followed by) identification of a perceived need and ‘news of an innovation’. The other two forms of knowledge: *how-to knowledge* and *principles knowledge* are thought to be sought following the development of awareness knowledge. (Rogers, 1995)

- The non-health board places were advertised by word of mouth and through an IASW newsletter, *Crossroads*, delivered to all social work agencies in the country.
- The programme was divided into two parts: An ‘introductory’ two-day programme for beginners not yet familiar with SFT; an ‘advanced’ two-day programme for those already familiar with SFT.
- A total of 70 practitioners and managers attended: 69 social work practitioners and managers and one residential child care manager.
- 15 attended for the full four days; the remaining 55 attended for either the Introductory two days or the Advanced two days.

### **Training format and focus**

As the motivations, perceptions and decision-making processes of the participants are the main foci of this study, some initial points need to be made about the course itself:

1. The course format, including the status and style of the presenter and the combination of teaching methods used, approached an ideal continuing professional development course as it combined: information-giving; skills exercises; video demonstrations of work with clients; live ‘master-class’ using course participants in role plays; handouts covering key concepts; active linking with the participants’ own experiences; and discussion about potential problems in the use of SFT, in particular in statutory settings.
2. It was a short course consisting at most of 6 hours per day teaching input, with no formalised follow-up or agency-based support organised. The workers who attended left, therefore, with either 12 or 24 hours input in total<sup>173</sup>. Following the course, they were essentially left to their own devices in relation to their use of SFT.
3. Iveson’s course offered the participants an interpretation of SFT which had been tailored for *social work practice* in the British Isles. While there are some contextual and policy differences in the practice of social work in the UK and Ireland, there is a common value base and similar concerns about the struggle to maintain a social work ethos within the realities of statutory practice in both jurisdictions.
4. The emphasis placed by Iveson on respect for the client, the notion of increasing client choice, and acceptance of the restrictions imposed by statutory obligations, all contrived to place the approach closer to the ethos and working realities of the participants than would a presentation by an American family therapy ‘expert’. This mediating factor may be significant for the participants’ assessment of SFT’s applicability to their own practice.
5. The Dublin course was not focused on teaching a theory of change or intervention alone, nor was it solely concerned with teaching SFT skills and strategies for change, but also aimed to challenge and question the participants’ *cognitive perceptions* of the work they did, and of their clients, through questioning established explanatory theories and practice methods.

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<sup>173</sup> Although, as will be demonstrated, several were already familiar with the approach.

6. The course notes (Appendix A) start with the assumptions or beliefs upon which this approach is based and end with the statement that:

Solution focused brief therapy embodies a set of principles which can be adapted to many areas of work outside the strict confines of therapy' (Appendix A).

This signals the orientation of the programme to impart a *philosophy* of practice in the shape of a set of principles, as well as specific skills and techniques.

#### PROFILE OF THE RESEARCH SUBJECTS

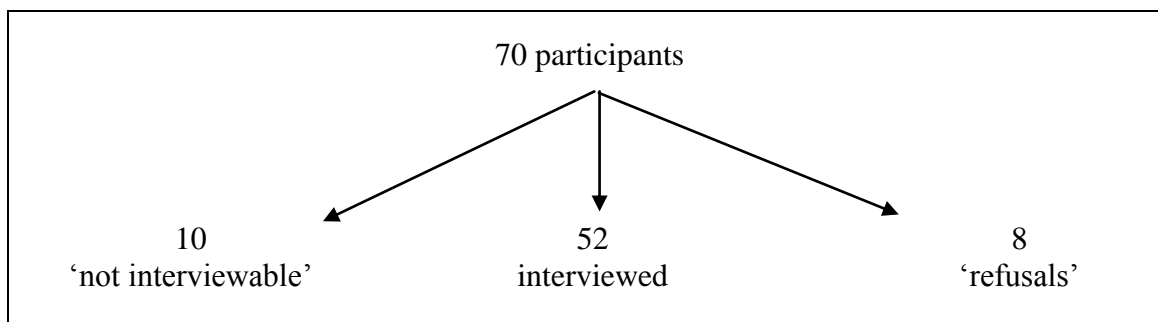
A total of 70 people attended the event and 52 were successfully interviewed 12-16 months later, in the period October 1996-February 1997. Of the remaining 18:

10 were not interviewable<sup>174</sup>

8 were considered 'refusals'<sup>175</sup>

Of the total number of 70 participants, 60 were eligible for interview a year later, and 52 (over 86%) were interviewed<sup>176</sup>. This group of 52 forms the respondent cohort for this study.

Figure 6: Profile of the research subjects



#### Qualifications

All but one of the respondents had professional social work qualifications.

#### Time of qualification

11.5% of respondents were newly qualified<sup>177</sup> and over 40% of the respondents had been qualified 5 years or less. The remaining 60% had qualified between 5 and 30 years previously.

<sup>174</sup> These participants had either left social work; were on long-term sick leave or had attended the course as academics.

<sup>175</sup> These respondents received initial approaches to be involved in the research (by letter) and by subsequent phone contact. Three attempts to establish contact were made before concluding that they did not wish to participate or could not be contacted.

<sup>176</sup> None of the 52 with whom direct contact was established refused to be involved in the research.

<sup>177</sup> Meaning that they had qualified in June 1995, some four months prior to the training.



## Gender

Of the 52 respondents, 41 (79%) were female and 11 (21%) male.

## Status of respondents

Of the 52 respondents: **43 (83%)** were practitioners<sup>178</sup>  
**9 (17%)** were managers at the time of training.

**41 (79%)** were employed by the local health board which hosted the training at the time of the training<sup>179</sup>.

**11 (21%)** were employed in non-health board settings.

## *The managers*

Of the nine managers, *six were Health Board managers:*

Four were team leaders or seniors in the community care service<sup>180</sup>

One was a residential child care manager

One was a senior in a specialist fostering and adoption unit.

The remaining three were from non-health board settings:

Two from voluntary organisations

One from a child psychiatry service<sup>181</sup>

## *The practitioners*

Of the 43 practitioners, 35 were in health board employment and 8 were in other services at the time of the course.

Table 1: The 35 health board practitioners by setting

Generic community care	20
Specialist community care <sup>182</sup>	8
Child/Adult Psychiatry	2
Fostering and Adoption Unit	3
Other <sup>183</sup>	2

<sup>178</sup> Two of the 43 practitioners who later became managers were interviewed as practitioners, as most of their experience in the intervening year was in direct practice.

<sup>179</sup> By the time of follow-up 12 months later, 2 of the 39 had moved to other health boards outside Dublin.

<sup>180</sup> The team leader grade had been introduced in 1990, and the senior social work grade was being phased out at the time of this study.

<sup>181</sup> The child psychiatry services in this region are either provided by the health board directly or by voluntary organisations contracted by the health board to provide child and family psychiatry services.

<sup>182</sup> The specialist community care posts comprised of 6 community-based fostering workers; one family centre social worker and one worker for homeless youth.

<sup>183</sup> The 2 'others' consisted of one counsellor and one 'out-of-hours' social worker.

Table 2: The 8 non-health board practitioners by setting

General medical	4
Elderly medical	2
Child psychiatry	2

### Generic, specialist and therapeutic services

In this study, some distinctions will be made between different ‘types’ of settings, as SFT might appeal and be applied to varying degrees differently, depending on the role and function of the practitioner in different settings.

Table 3: Generic, specialist and therapeutic posts

Generic 184	Specialist 185	Therapeutic 186
25	12	6

N = 43 (practitioners only)

### Breakdown of respondents by setting and role

An overview is now given of the complete cohort of research subjects in relation to their setting and role.

Table 4: Total respondent group by setting (N=52)

Child Protection	21 Practitioners	4 Managers
Specialist community care	8 Practitioners	
Fostering & Adoption Unit	3 Practitioners	1 Manager
Child Psychiatry	3 Practitioners	1 Practitioner/Manager <sup>1</sup>
Medical Social Work	4 Practitioners	
Elderly Medicine	2 Practitioners	
Adult Psychiatry	1 Practitioner	
Counsellor	1 Practitioner	
2 Voluntary Organisations		2 Practitioner/Managers
Residential Child Care		1 Manager
<b>Total</b>	<b>43</b>	<b>9</b>

<sup>184</sup> Generic posts: community care and general medical posts which offer a broad social work service, encompassing environmental, practical, interpersonal, individual and psychological aspects of need.

<sup>185</sup> Specialist posts: for example, fostering and voluntary specialist services for specific groups.

<sup>186</sup> Therapeutic posts: traditionally offering interpersonal psychological help to individuals, couples and families who are seeking help. Such services include child and family psychiatry, adult psychiatry, counselling and family centres. Social workers in adult psychiatry in Ireland have no function in relation to involuntary admissions.

### Qualification range by post held

Table 5: Length of post-qualification experience (n= 52)<sup>187</sup>

Less than 5 years	<b>19</b> (40.4%)
5-10 years	<b>9</b> (15.4%)
10-15 years	<b>9</b> (15.4%)
15-20 years	<b>10</b> (19.2%)
20-25 years	<b>4</b> ( 7.2%)
More than 25 years	<b>1</b> ( 1.9%)

Fifteen of those qualified five years or less (19 in total) were employed in frontline community care posts, with the remaining four divided between child psychiatry, specialist medical and fostering posts and a single manager post in a voluntary organisation.

When these figures are contrasted with those depicting the work settings of the group as a whole, it becomes evident that a clear trend exists in this cohort, whereby those with less experience are concentrated in frontline community care posts, and those with more experience are in specialist health board or non-health board practitioner posts, or in management positions. This trend for newly-qualified workers to be concentrated in frontline child protection services has since been verified (NSWQB, 2000).

### Geographical location of respondents<sup>188</sup>

The respondents came from a total of nineteen different locations, twelve from within the health board structure and seven from outside agencies.

The range of settings represented suggests that interest in the SFT course ran across most social work settings<sup>189</sup>. One sector of significance<sup>190</sup> not represented in this cohort is that of the probation and welfare service. The reasons for this are unclear and outside the remit of this study<sup>191</sup>. Another group clearly missing from this cohort are those in community work and community development posts. Given the nature of the SFT innovation, it is possible that those whose role and function is

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<sup>187</sup> A cautionary note needs to be sounded as 'time since qualification' does not necessarily equate with level of experience: some workers have been employed as unqualified social workers prior to qualification; others have taken career breaks, leaves of absence or worked in non-social work employment since qualification. It does, however, indicate the range of experience within the respondent group.

<sup>188</sup> The respondents were placed in these categories according to either the health board areas or non-health board settings they were located within. In the case of EHB Area B, two respondents a little outside the system were also assigned to this area as they were allocated their places by the manager there.

<sup>189</sup> Allowing for the fact that as a health board community care initiative, the majority of those attending came from that sector.

<sup>190</sup> Of significance in terms of the numbers employed.

<sup>191</sup> One potential factor may have been the existence of an established and strong training unit within the probation and welfare service. Workers in this service may be more dependent on internal organisational training than workers from the other sectors who lacked strong internal training units, and consequently less likely to attend a course provided by another social work service.

focused on structural change and community/local development are less likely to find methods of practice focused on individual change of appeal<sup>192</sup>.

All ten geographical area teams and one specialist unit in the EHB were represented in the cohort, but there was a significant variation in the numbers who attended from different locations. The different health board area teams are presented in an anonymised form in order to protect the identity of individual respondents. The initial policy for allocating places on the Dublin course was that a total of four were offered to each area. Surplus places were re-allocated to areas asking for additional places.

Table 6: Number of Course Participants by Location

EHB Area A;	8
EHB Areas B, C & D;	5
EHB Specialist Fostering and Adoption Unit;	4
EHB Area E and one medical setting;	3
EHB Areas F, G & H, one child psychiatry and one medicine for the elderly setting;	2
EHB Area I & J, two voluntary organisations, one medical and two 'other' <sup>193</sup> .	1

#### WHAT PROMPTED INDIVIDUAL SOCIAL WORKERS TO ATTEND A COURSE IN SFT?

At the time of the initial decision to attend the Dublin SFT course:

37 'newcomers' were at the beginning of the process (Stage One), were seeking knowledge for the first time;

15 'returnees' returning for a second bout of training, were at different points in the innovation-decision process: six were deemed to be still at the persuasion/ decision stage (Stage Two) and nine were deemed to be already successful adopters of the approach (Stage Four)<sup>194</sup>.

Table 7: Reasons for attending training and stage in innovation-decision process (after Rogers 1995)

<b>Stage One</b> Knowledge seeking	<b>Stage Two</b> Persuasion/decision	<b>Stage Three</b> Experimentation & Review	<b>Stage Four</b> Adoption & Implementation
37	6	0	9

<sup>192</sup> Individual is used as a term here in contrast to Environmental and refers to work on the personal level with individuals, couples, and families.

<sup>193</sup> The two 'other' were from one residential setting and one counselling setting.

<sup>194</sup> The latter group included the course organiser, a manager who was also acting as 'product champion'.

**(i)Stage One ( Knowledge-seeking) respondents**

‘When an individual (or other decision-making unit) is exposed to an innovation’s existence and gains some understanding of how it functions’ (Rogers, 1995: 162), the innovation-decision process commences.

The group of 37 at the beginning of this process cited a number of reasons for attending the training event. Some expansion of Rogers’ suggested categories of ‘prior conditions’<sup>195</sup> was needed, both to allow for sub-categories and to differentiate between those who chose to attend the course and those who were sent by managers. Allowances also had to be made for multiple reasons for attending, so the number of factors cited is greater than the total number of respondents who attended. While my study concentrates on factors relating to the innovation, other motives (and benefits) may well have been in existence for the respondents but not detailed in the research interviews<sup>196</sup>.

**Prior conditions**

Table 8: Factors influencing decision to ‘seek knowledge’ (N = 37)

<b>Factor</b>	<b>Characteristics</b>	<b>Number</b>	<b>Totals</b>
1. Previous practice	Placement and college teaching	4	
Total			4
2. Felt needs/problems	Disappointment with traditional models	2	
	Appeal of short/brief method	9	
	‘Stuck’/chronic cases	3	
Total			14
3. Innovativeness	New approach	11	
Total			11
4. Norms of social system	Peers using / demonstrating/ informing	19	
	Manager-led	9	
	Training opportunity	3	
Total			31
<b>Combined total</b>			<b>60</b>

**Factor One: Previous practice**

Several of the newer graduates already ‘knew about’ SFT, either through lectures in college or through placement experience. Four recent graduates cited previous practice as a factor in the development of ‘awareness-knowledge’. Three of these graduates had qualified only months before

<sup>195</sup> Rogers’ prior conditions consist of: previous practice; felt needs/perceived problems; the appeal of innovativeness; and the norms of the social system (1995).

<sup>196</sup> Such as general professional development; taking ‘time out’ from a busy working week; assisting promotion or job mobility; relieving stress; obtaining time to reflect on the work; networking and meeting up with friends and colleagues from other locations.

the training; the fourth, qualified two years at the time of the Dublin course, had come across SFT while on a placement abroad<sup>197</sup>. One had what might be termed basic existence knowledge:

*We touched on it briefly in college and I wanted to go [on the training] because I wanted to expand more on brief therapy to see if I could apply it with my own clients and in my work.*

Another had already tried to develop use of SFT:

*I had been interested in it and I had tried a little and read about it in my fourth year, my final year placement.*

The other two who had seen SFT in practice on placement had a different type of knowledge about it, in that they had witnessed some 'how-to' knowledge in practice and appeared more engaged with it as a potential practice model. One had prior knowledge through a placement in a Scandinavian country where he had come across de Shazer's work:

*I was familiar with the concepts around brief solution focused therapy ... I had seen it in action and read about it a bit while I was there on placement and had been unable to practise it there primarily because of language constraints ... So really I was familiar with the concepts and had seen it in operation and was attracted to it.*

The fourth said that:

*I had been exposed to brief therapy on a placement in college by my practice teacher and I really wanted to go myself [on the course].*

This fourth respondent was, following qualification, in a temporary locum position in an area where there was already a climate of use (Area A). She was not eligible for one of the free places, but initiated contact with the course organiser to secure a place for herself.

### **Factor Two: Felt needs/problems**

A need is a state of dissatisfaction or frustration that occurs when one's desires outweigh one's actualities. (Rogers, 1995: 164)

Fourteen of the 37 newcomers cited factors in this category as influencing in their decision to attend the course. Two recent graduates (qualified less than two years at the time of the course) referred to dissatisfaction with 'traditional' or established modes of practice:

*It was about trying to do things slightly differently ... the old way is not going to solve all the difficulties that we have ... it was [a] need to do something differently because the old way was crumbling ... the old way was very task-oriented, very problem-focused ... the thing was a lot of social workers were going in on one problem and finding more problems and thinking they had to work on all those and that's what I would call the old style really. (Child Protection social worker)*

*Maybe feeling that there was more to social work than the traditional theories and things that we'd been taught. (Child Protection social worker)*

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<sup>197</sup> All three social work training courses in Ireland were represented in this small group indicating that by 1995 SFT was being introduced into professional social work training in all the colleges.

A further nine specified a desire to learn brief methods. As the following quotes illustrate, there was, for some, a sense of frustration with the longer-term types of work they were engaged in, which they tended to describe in problematic terms:

*I suppose I liked the idea of having very brief focused work rather than the kind of protracted stuff that I had been used to doing. (Child Protection Duty social worker)*

*... because it was brief, and a lot of the counselling can go on and on and on, often meandering on and leading nowhere. (Medical social worker)*

Others described the felt need in different ways:

*It was one of the things we were talking about doing – family assessments in the resource centre ... having families in for brief therapy ... short sessional work with them ... we were setting up an assessment service and I was interested in doing some short work. (Family Centre social worker)*

*It sounded very appropriate – given the setting we're in, where there are often time limits in terms of the amount of time you can work with somebody ... and the feeling that there was a positive orientation – a possibility for change. (Child Protection social worker)*

*I was interested in it because our centre tends to have a very short-term approach, partly because it tends to suit a lot of the clients who attend our centre. They don't want to be coming for long periods of time – they just want to be coming for short periods of time so we would tend to shape our work so that we get the maximum change within the time span they are willing to attend. (Child Psychiatry social worker)*

Three practitioners described their need for new approaches which could offer something to stuck or chronic cases:

*I thought it might be a very interesting approach to the intransigent types of cases where you can get locked into a particular way of dealing with the problems ... cases that don't seem to get anywhere. (Fostering social worker)*

*A different point of view, a new approach, to working with families who were ... really long term or chronic difficulties. (Child Protection social worker)*

*I thought it might be useful particularly in relation to supporting foster parents because you are probably aware yourself, you can get very stuck looking at what's wrong ... it can make it a bit stuck, so I was hoping to take on a different approach and use a different strategy for moving them because sometimes I get stuck in that too. (Fostering social worker)*

### **Factor Three: Innovativeness**

Eleven of the 37 mentioned the innovativeness of the approach as a particular attraction. For some, the primary appeal of the approach was that it was 'new' and fashionable and this fitted for some with the professional expectation that one should engage in continued professional development:

*I'm always interested in any new therapies or ... I'm always interested in new techniques which can be incorporated ... as long as they are not things that I would have a problem with implementing or a problem signing up to the tenets of it. (Medical social worker)*

*It just sounded like something I'd be interested in getting involved with, in some kind of new innovation. (Child Protection social worker)*

*I hadn't any previous knowledge of brief therapy, and just in talking about it, I felt it was something, something relatively new and something that, you know, would be good to find*

*out more about and to experience and to see what use it might have. (Health Board manager)*

*It sounded different, interesting and I thought I'd like to go along. (Medical social worker)*

A very experienced practitioner described her need to keep in touch with new approaches as she supervised students on placements:

*I think, when you are qualified for so long, you need to go and look at different things and I always feel I get the heebie-jeebies getting a new student that I won't know what they are talking about. (Medical social worker)*

In this case, the motivation for attending appears to be related to the respondent's work as a practice teacher (and possibly her *credibility* as a practice teacher) rather than a specific interest in SFT for her own practice.

#### ***Factor Four: Norms of the social system***

*The influence of peers:* Nineteen of the 37 respondents mentioned contact with peers who viewed SFT favourably as a factor in their decision to attend the course. Contact with peers ranged from having colleagues in the same location or setting actively using SFT to hearing about it through informal channels of communication, such as friends:

*I had heard a little from one member of the team, who had been involved in some previous training and she thought it was quite beneficial. (Child Protection social worker)*

*Through [a product champion] ... and the information that had filtered down through the health board ... people found it useful ... I heard positive reports about it and I thought it might be a useful one to look in on at least. (Fostering social worker)*

*I had just heard bits and pieces about it and a couple of people on the team had gone on training previously and I was just aware that they were trying to get something going in relation to it and it sounded interesting. (Child Protection social worker)*

*A postgrad. that I was in college with was talking about brief therapy and she had been using a bit of it and it sounded wonderful. (Child Protection social worker)*

A *product champion* emerged as one messenger of importance: three of the participants, two of whom were located outside the health board area, mentioned her specifically as the source of information and encouragement:

*It was [the product champion] who is my direct line manager, alerted me that this training was taking place ... just in talking about it, I felt ... it was something ... that would be good to find out more about.*

*The first I heard – [the product champion] mentioned it to me that it was on. I was interested in the concept of it.*

The positive assessment of peers did not translate into automatic appeal for all:

*I had missed [a previous presentation to the team] – so I had heard second-hand about it – and I had also heard about it from other colleagues in the community. I was a little bit confused about it, not knowing the full story. (Medical social worker)*

*People had already done the training before ... and had been quite positive about it ... initially I was negative ... the negativity wasn't anything to do with knowledge or*



*information – it was more to do with, you know: Oh God, there's another sort of fad coming or going called brief therapy.* (Child Protection social worker)

#### *Manager-led*

Following the findings of Joyce & Kenefick (1997) that peer-led training initiatives are positively received, and those of Quinones (1997) that participants who are involved in training decisions have increased motivation to learn, I suggest that in-service courses which are initiated by practitioners and frontline managers may be as, or more, positively received than those initiated by centralised managers. Thus, one can hypothesise that practitioners who are 'sent' on courses by managers, rather than choosing to attend themselves, may be affected by this 'external' factor when considering the value or relevance of the course.

In this cohort of practitioners, the majority who attended the Dublin course did so of their own volition, and gave a variety of reasons for their decision. Of the 37 who were new to SFT, nine indicated that SFT had been introduced and the course had either been suggested by managers, or that their names had actually been put down for the course without consultation. Three were from related medical settings:

*It would have been introduced by our head social worker here ... seen as quite a new and innovative way of working with different clients;*

and another three were from one health board area where a new intake system was being developed:

*At the time we were actively planning towards our new intake system and it was felt by management that the training might be useful for them.* (Area C social worker)

*My recollection is that my name was put forward here by my manager at the time ... some of the members of my team would have been involved in brief therapy ... And I suppose she felt that it would be important for me to have at least an awareness of brief therapy.* (Area C manager)

The remaining three consisted of one child protection manager, one residential manager and one child protection practitioner from three different areas. The area practitioner was just back from a period of leave. She went on the course without really knowing what it was about, remembered little of the content and had no ambition to try SFT out. She was, in her own words, just back from a period of extended sick leave related to stress and saw the course as 'a change from work – two days out, really'.

These nine respondents were less enthusiastic about the course and about SFT than those who stated that it had been their decision to attend. Only one of the nine, an experienced practitioner who had just moved into the community care setting as a team leader, indicated that she was also anxious to attend as there was already a 'climate of use' in the area.

### *Training opportunity*

Three respondents indicated that they attended the course because it was a training event rather than because of any perceived need or attraction to SFT.

*The circular came around. Not many training opportunities – I go for most anyway.*

*I was told that the thing was coming up and that if I'd like to do it that I can go on it ... it would be a change ... I'd never heard about it [SFT] before.*

The third was a manager:

*Nobody else wanted to go ... so there was a place and I felt it would be a bit of a waste so I went.*

***Right. Okay, and would you have had any interest in it otherwise?***

*No.*

***Had you heard anything about the approach before you got the circular on the training?***

*No.*

These respondents did not attend the Dublin course to seek information about a new innovation. They saw it of value primarily because it was an event they *should* engage with, not because of any characteristics of SFT or influence from peers.

Availing of a training opportunity can also be seen as a 'norm'<sup>198</sup> within the social system because of the expectation that social workers will continue post-professional development through such activities.

### **STAGE TWO/THREE RESPONDENTS**

At the persuasion stage in the innovation-decision process, the individual forms a favourable or unfavourable attitude towards the innovation ... the main type of thinking at the persuasion function is affective ... the individual becomes more psychologically involved with the innovation: he or she actively seeks information about the new idea... selective perception is important in determining the individual's behaviour at the persuasion stage for it is at the persuasion stage that a *general perception* of the innovation is developed ... perceived attributes of an innovation are especially important at this stage. (Rogers, 1995: 168, my emphasis)

Six respondents were deemed to be at Stage Two in the innovation-decision process at the time of attending the Dublin course. All had attended previous SFT courses. They were potentially 'later adopters' (Rogers, 1995) but, for reasons which will be explored, did not proceed further along the cycle of innovation-adoption.

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<sup>198</sup> Rogers, 1995.

### **Characteristics of respondents**

One EHB Area E (child protection social worker)

One EHB Area B (fostering social worker)

One EHB Area C (fostering social worker)

One EHB Area J (fostering social worker)

One Child Psychiatry (manager)

One Voluntary Agency (manager)

### **Reasons for attending the course**

All six had attended the previous Introductory two-day course in March 1994 run by the same trainer and were returning for additional knowledge<sup>199</sup>. The type of knowledge they were seeking was primarily that of skills development or more ‘how-to’ knowledge<sup>200</sup>.

Four had felt insufficiently equipped or motivated to implement SFT in a planned way following the previous course, and were returning for additional knowledge – they had developed ‘awareness-knowledge’ and some basic ‘how-to’ knowledge, but still needed persuasion. This was particularly evident among the fostering workers in the group:

*I had gone to the original course in Marino. I felt that I had not really got my head around it that well and I wanted to see more of it ... that is my biggest problem with brief therapy – that you need to practise it a lot and you need to see [it]. (Fostering social worker)*

*[Attended the second course] to really get more to grips with actually using it ... the first two days one was really trying to take in a new approach ... at that point in time I suppose I was very involved in doing assessments ... but I wasn't in a situation where I could actually work with somebody. (Fostering social worker)*

*The Voluntary Agency manager* had been working in a health board setting at the time of the first course and said that she had tried to use SFT there, had temporarily abandoned it, but saw more potential for its use in her new setting and so returned to the second course:

*I had previously attended the training ... in 1994 ... and I had tried to use it in my work in community care and I felt I needed more training and more support around using it ... I felt it would be particularly useful for using with [sensory deprived] clients where there are particular communication problems so I felt it would be relevant to here. (Voluntary agency manager)*

*The child psychiatry manager* was unable to recall the detail of her attendance at the two courses: for her, the two had blurred into one:

*I think I did the four [days] but, to be honest with you, I think I've been back to two different blocks that he did but I'm not really sure ... I knew vaguely about the theory but wasn't familiar with it and had read a bit about it and knew that it was effective ... the*

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<sup>199</sup> The outcomes for others who attended the first course in March 1994 but did not return to the following event are unknown.

<sup>200</sup> ‘information necessary to use an innovation properly’ (Rogers, 1995: 165).

*idea of short term work in order to move people on and would address the waiting list issues seemed very attractive.*

***What interested you in the first two days that ... made you come back for the second two days?***

*I think applying what he had described in the first module ... it seemed to be something that was an extra tool that was effective and useful ... in situations that are either stuck where there had been ... years of contact and not an awful lot of change, or paralysis that the families and the team dealing were stuck, and this new way of approaching things seemed very useful and gets results.*

Another motivator for attendance at the Dublin course for this child psychiatric manager was of networking and sharing interests with colleagues who would be referrers to her service. The interagency mix she described as ‘*an added and important component to it*’ and that having different agencies together was

*... very, very useful, and I mean I would have had both feedback and a ripple effect from that because you keep in with people. Since then you know it’s sort of a common bond in some ways. It was quite powerful, that aspect of it.*

### **Experimentation with the approach**

Only two of the six at Stage Two at the time of the Dublin course had experimented with SFT between March 1994-October 1995. Both were Child Protection social workers, from different areas:

*My own experience was that I used it with a family situation ... where the mother really was in denial about her problems and no matter how positive the approach was, she still really remains in denial at the end of it and it was unfortunate that that happened to be the case that I chose to try to really apply it really properly.*

***Did that have quite an effect on you ... in terms of whether you felt like continuing to use it or not?***

*I suppose it did have quite a profound effect ... it seemed such a situation that was difficult to deal with really... a chronic situation really. I thought that the brief therapy approach would offer something different ... that’s what made me think of it and I just happened to be dealing with it at the time, that was the other thing. It just happened to be...*

***The most pressing case on your mind?***

*It was, it was really at the time.*

These respondents appear to have moved from the persuasion-decision stage through to Stage Three (experimentation and review) before the Dublin course, but because of difficulties in using SFT, became less certain of their own ability and of SFT itself. They thus returned to Stage Two and attended the second course to obtain more ‘*how-to*’ knowledge and to re-evaluate the relevance of SFT for their practice. They might have rejected SFT but instead retained sufficient interest to seek additional information to deal with the dissonance that had occurred as a result of their attraction to SFT and subsequent difficulties in implementation.

## STAGE FOUR RESPONDENTS

Nine respondents were assessed as adopters of SFT. They were from eight different locations and a range of settings:

- One voluntary agency manager
- One medical social worker
- Two child psychiatry social workers (in different settings)
- One adult psychiatry social worker
- One fostering social worker
- Two Area A social workers
- One Area B manager.

They had been exposed to SFT, had become persuaded of its benefits, had implemented it without uncertainty or dissonance, and had adopted it and maintained a level of usage and commitment, so that they saw themselves as adopters. Eight of the nine had used SFT directly in their practice, including the voluntary agency manager who retained a direct practice input. The ninth, a product champion, had encouraged use by practitioners in her area, but following organisational changes in 1995 had less direct input into supervising practice.

Seven of the nine had attended the prior course in March 1994, run by Iveson; another had attended a course in London with the Iveson group Brief Therapy Practice; and one had attended a course in the autumn of 1994 run by two other English trainers in Dublin.

Excluding the three community care respondents, the remaining six had attended both their prior courses and the current one as solo representatives from their agencies and locations.

### Reasons for attending

Apart from the course organiser<sup>201</sup>, all others indicated that they attended this SFT course for skills development and/or a ‘refresher’. They had all received enough awareness and ‘how-to’ knowledge from their prior course(s) to feel able to implement SFT in their practice, but returned for one of four reasons:

(a) *they wished to develop their skills further*

[I wanted] *to become more skilful at it. I understood the theory behind it but I just wanted more exposure ... see it more in practice – more videos, more role-play – just to get more ideas.* (Medical social worker)

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<sup>201</sup> The course organiser indicated that she had ‘sat in on’ rather than actively involving herself in the training input.

**(b) because implementation of SFT had become interrupted through changes of job or location**

One respondent who had already used it ‘with very effective results in child protection/child care settings’ in another country described how

*... one of the main interests I had in my work was in developing the approach, so when I came back to Ireland I was very keen on it, I had done presentations and so forth, so when I saw the training, I was keen to make contact and also get a refresher. (Child Psychiatry social worker)*

Another who had used it in a health board child protection setting after the first course ‘found it a very good way of engaging clients initially [when] your goal is to build up trust’, and when she subsequently moved to a specialist post was ‘very anxious to continue it because I thought my skills were developing ... I was just hopefully trying to continue [using it] ... to adapt’.

**(c) because they had identified additional perceived needs which they thought could be addressed through use of SFT**

*By the time I heard about the second, the advanced training [I] was quite enthusiastic ... I had a particular interest in terms of looking at dealing with involuntary clients. (Child Protection social worker)*

**(d) for reassurance/consultation**

Three of the respondents (a voluntary agency manager; adult psychiatry practitioner and one of the child psychiatry practitioners) were in single-handed social work posts and for these in particular the need for reassurance and reinforcement of the innovation-adoption decision was obvious:

*I think I realised after the first one [course] that I fell into the tendency that I think everyone does – I was trying to make it more complicated than it really was, so I was screwing it up a little bit ... I had tried it and I was excited about it because there had been good results. (Voluntary agency manager)*

*I had already been using it but was finding it difficult to draw myself on ... I was even carrying around the initial handout that Chris had given us on the first course and I had it in my diary to try to remind myself: what else can I ask this person? How else can I apply it? (Adult psychiatry social worker)*

*... after the first two days and I had been reading it and trying to do it out of the book, and it was almost like the first two days was almost a confirmation that I wasn't on the wrong track....that I wasn't doing harm, a bit of affirmation really ... (Child psychiatry social worker)*

**Stage Four Respondents and Extent of SFT use**

All reported at least partial success in their implementation of SFT between their first course and their arrival at the second. While all found SFT had appeal, the extent of and rationale for the appeal varied:

- three viewed it as a significant development in their practice;
- five reported using it selectively; and

- one used it as a ‘last resort’ when her usual approach failed: *‘to be honest ... when I find myself at an impasse, when I’m not really reaching somebody, I would begin to use it and found that extremely useful.’* (Medical social worker)

#### **RESPONDENTS’ EVALUATION OF THE SHORT COURSE**

The course was positively received by most of the respondents (49 out of 52). It was categorised as either excellent or very good by thirty seven respondents, some 73% of the total number of respondents. An additional twelve respondents rated it as good. These figures indicate that, overall, the course was well received by the participants.

- Positive features of the course mentioned by a number of respondents were: the presenter (his skill level; practitioner status; positive and energetic approach; personality and humility); the varied programme which kept participants working hard and engaged throughout the course; the intensity of the experience and the relative values of a two or four day course; the mix of participants from across the health board and also cross-agency; pairs exercises and the use of own case material.
- Negative features included: the length of the course (those who attended for four days found this too tiring and concentrated); daunting experiential exercises.
- Three of the 52 respondents were deemed to have viewed the course as either ‘ok’ or ‘not good’. These negative ratings are of note because all three respondents came from the same setting and working as colleagues. They were lukewarm both about the presenter and SFT and this appeared to have also put them off the course itself. While one of the three saw some potential in aspects of SFT that were similar to a practice model he was already using, all three were critical of the presenter – one thought he ‘droned on a lot’ and was not responsive to his audience (a perception markedly at variance to that of the majority of respondents). The other two respondents thought that the presenter was too positive about SFT, and this led to an aversion to put both the trainer and the approach.

#### **CONCLUSION**

The cohort of social work practitioners and managers who comprise the respondent group were diverse in levels of post-qualification experience; agency settings; social work role and geographical location.

The existence of clusters of practitioners from particular settings and locations suggested that prior to this short course, clusters of interest in the innovation existed.

Of the 52 respondents, 37 were ‘newcomers’ to SFT and can be said to have been at Stage One of the innovation-decision process (the ‘awareness-knowledge’ stage). These respondents were aware that SFT existed and elected to attend the Dublin course to develop further this awareness-knowledge and also to seek ‘how-to knowledge’ and ‘principles knowledge’ (Rogers, 1995). A number had not elected to attend but had been ‘sent’ by managers. The effect on their motivation to learn about or engage with the SFT innovation was marked.

The remaining 15 were ‘returnees’ who had already developed awareness-knowledge and some ‘how-to knowledge’ from previous courses. These were not all committed to SFT but were at different stages in the innovation-decision process. Six appeared to be still at Stage Two (persuasion/decision) of the process, and nine considered themselves to be adopters (Stage Four). These two sub-groups had different learning needs, for example, those still at Stage Two needed to see SFT in action again and think about its applicability; those at Stage Four had more specific queries regarding its use.

For the six who remained undecided about SFT, the primary need was to develop sufficient knowledge and skills to enable them to use the innovation with confidence, but coupled with this was their uncertainty regarding the innovation. They were still assessing its characteristics<sup>202</sup> in an effort to reach a decision on whether to implement or reject. One respondent indicated a motive for attending the course that was unrelated to the innovation itself but entailed the need for networking and sharing material with colleagues from other agencies. For her, this was a significant benefit.

The nine who already saw themselves as confirmed adopters of SFT returned for further skills development; for a refresher in the approach for those whose implementation had been interrupted by changes of employment or illness; because their implementation to date had thrown up new perceived needs which they now wished to address; or, in the case of solo adopters, for reassurance/consultation.

The majority of respondents evaluated the course as being ‘very good’ or ‘good’. Satisfaction with the course itself and training-related factors was very high. The three respondents who were at best lukewarm about the course formed a cluster from one setting, and were also rejecters of the approach.

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<sup>202</sup> Rogers (1995) outlines five characteristics which, as perceived by individuals, will help to explain differing rates of adoption: (i) relative advantage; (ii) compatibility; (iii) complexity; (iv) trialability; and (v) observability. These will be reviewed more fully later.



## CHAPTER NINE: ‘THE DUBLIN COURSE’ – INTERPRETATIONS OF SFT

### INTRODUCTION

The Diffusion of Innovation literature emphasises the importance of individual perception in the innovation-decision process:

Even in the case of an overwhelmingly advantageous innovation, individuals in the potential audience for the innovation may perceive it in the light of many different values....to understand their behavior in adopting or rejecting the innovation, the researcher must be capable of taking their various points of view. Simply to regard adoption of an innovation as rational (defined as use of the most effective means to reach a given end) and to classify rejection as wrong or stupid is to fail to understand that individual innovation-decisions are idiosyncratic and particularistic. They are based on the individual’s perceptions of the innovation. (Rogers, 1995: 111)

In this chapter, the respondents’ perceptions of the innovation will be mapped in an attempt to develop such an understanding. All 52 respondents were questioned on their perceptions of SFT to elicit data on:

- (a) Their understanding of the approach (what did they see as its central elements?); and
- (b) their assessment of it as a practice approach (did it appeal and arouse interest or not?).

### UNDERSTANDING OF THE APPROACH

It is by no means certain that what a trainer or educator sets out to impart to a group of trainees will correspond with what that group actually learns from the teaching process. Learning theory reviewed in Chapter Five suggests that perception, cognition and degree of interest all play a part in processing the knowledge and experiences that a particular training event offers. Individuals will, the literature suggests (DHSS, 1978; Harrison, 1991) vary in their interpretations of a particular practice theory, and what (if anything) they set out to do with it will depend on their ‘reading’ of the theory.

In an attempt to elicit this data the respondents in this study were asked to describe what they saw as the ‘central aspects or elements’ of SFT.

Table 9: General levels of recall<sup>203</sup>

No detail	Vague recall	Detailed recall
4	3	45

Of the 52 respondents, 7 either could not remember any detail (4) or gave general answers (3) such as ‘positives and praising’ or ‘magic wand’ which indicated a lack of specific recall. The four who

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<sup>203</sup> As indicated in Chapter Six, ‘recall’ is an important aspect of research, and the salience of an event is seen to affect levels of recall (Foddy, 1993).

were unable to give any description were, unsurprisingly, among the group who did not attempt to use the approach subsequently. None of the three who described it in vague ways were active users at the time of interview, although two had attempted to use aspects. This lack of, or vague, recall combined with an absence of experimentation suggests that this specific course and its content was for these respondents of insufficient salience for recall to be possible (Foddy, 1993).

Of the remaining 45 respondents, most were able to describe three or more specific aspects of the approach. The question asked<sup>204</sup> was open-ended and there was clearly a variety of ways in which it could have been answered – for instance, the replies could have focused on the beliefs or values underpinning the approach, on techniques or interventions or on other aspects, such as its origins.

### **Specific aspects Recalled**

The two most commonly cited ‘elements’ were those of *The Miracle Question* and *Scaling*, both specific techniques. The next two most commonly cited elements were *Exceptions* and the focus on *Positives* (which included client strengths and resources).

### **General aspects Recalled**

In addition to the specific interventions, a number also identified and described more *process-centred* aspects of the approach which they felt were of particular significance:

- (i) the style and sequencing of questions;
- (ii) the emphasis on focused goal-identification;
- (iii) the use of ‘reframing’; and
- (iv) a belief in client strengths and resources.

These were less commonly mentioned than the four specific techniques, but were seen as central elements by a number of the respondents, and emerged as key aspects again in the descriptions of usage of the approach which will be addressed in a subsequent chapter.

The overall picture that emerges from the descriptions of the ‘central elements’ of the approach, however, is that it was the specific and prescriptive techniques or interventions along with the positive ethos of SFT which made most impression on the respondents in this study.

## **APPEAL OF THE APPROACH**

Table 10: Appeal of SFT.

Appealed/aroused interest	Mixed views	No appeal
46	2	4

<sup>204</sup> Along the lines of: If I had met you on the last day of the course, outside Marino, and had asked you: ‘what is this SFT all about’ what would you have said?

That the approach appealed to 46 (over 88%) of the respondents is a strong finding. The nature of this appeal and the features that were singled out by respondents as of particular significance will now be analysed. Before examining these aspects however, several factors need to be borne in mind:

- (a) The approach was ‘fashionable’ at the time.
- (b) Appeal or interest did not mean an unequivocal or uncritically positive reception. None of the respondents (including those who were already ‘converted’) saw it as the approach to solve all problems. Drawbacks, concerns and reservations were expressed, even among those who left the course feeling extremely positive about the approach.
- (c) The respondents’ initial reactions to SFT were always comparative, in the sense that they were comparing what it appeared to offer, with the theories, practices or forms of knowledge on which they were currently basing their work.

### **Analysis of the Appeal of the Approach**

In analysing the data relating to the appeal of the approach, two different techniques were utilised: firstly, a content analysis was carried out and a summary of the 52 respondents’ views of the approach as indicated through the use of terms and phrases, was compiled (Appendix C); secondly, a thematic analysis was carried out where the transcripts were scrutinised for the more detailed reflections by the respondents about the nature of the appeal which were then assigned to different categories.

Table 11: Categories of Appeal of SFT by frequency of mention

Focus on Client Strengths and Perspectives	24	46%
Brief/Pragmatic	17	32%
Hope	16	31%
Different /New	14	27%

#### ***The focus on client strengths and perspectives***

By far the most commonly cited feature was that it was a ‘positive’ approach, with 24 respondents in total (46%) spontaneously describing it so.

The positive description related to the way the approach was used, where a search for positives took place and where client strengths, resources and exceptions to the problem were identified and emphasised:

*I thought that it was a totally different way of approaching problems and seeking solutions and which I found quite refreshing. It very much concentrated on the positives. And the positives of the person that had the problem rather than working on the negative...the whole idea was a very positive one. And it left the person – the client, feeling some strengths and with something to give and with something despite all the chaos that was around them. (Medical social worker).*

Over two-thirds of the respondents described the approach in terms of its inclusiveness: the way it included the client, focused on the strengths and positives that the client brought and helped the client generate their own solutions. For some respondents this fitted with their view of the social work ethos:

*Well, I think it kind of fits in with the traditional values of social work in many ways – in terms of it's client-centred, it's focusing on the client in a very particular way – in a way that draws out the best in the client – so from that point of view I think that it's highly relevant. (Child Psychiatry social worker)*

A few mentioned its contrast with previously learnt theories:

*... the whole idea of looking at people's ability to cope – their positive skills; probably from my education [I] would have been more focused on understanding the dynamics of behaviour...they lead you to understand but don't necessarily lead you to help people alter what they are doing ... the big thing about brief therapy is actually looking at the strengths that people have, the whole survival, the spirit of people and the fact that's of value – the value is on how they have got this far and also on the whole idea of getting them to work on how can they use those again. They are part of their own treatment – they are sharing that. (Child Protection social worker)*

SFT was seen to be of particular appeal because it was a method with techniques focused on drawing out the strengths and perspectives of the client:

*That in the daily run you would be reminding the person really of the value they have as an individual, of their own power to cope and to move....I think that was what really appealed. In a sense one would attempt to be like that possibly before hearing about this programme ... but this gives structure to it and maybe techniques. It is the way ideally that one should be working ... The feelings would be there and I'm sure with most social workers – that you would want to appreciate the person but somehow the approach, the way it's actually put, it just reminds me of the essence of that – when you are confronted with other agendas you might have in relation to your role, your statutory role perhaps. (Child Protection social worker)*

*What struck me was that you put it back to the client to come up with what they thought they might be able to work with rather than us going in and preaching ... and hitting off a wall a lot of the time we are, with that. Because sometimes I think with the approach that we tend to take, we are not really listening to where they are, so that's what I thought was good about it – that they would come up with the agenda (Fostering social worker)*

A number of respondents mentioned the *specific techniques* which elicited the client's perspective (especially the Miracle Question and scaling) as having a particular potential:

*Putting things on scales – I thought that was good, and again it was the client's perception of where they were, not yours. You are making your assumptions with the assessment, you are also making the client look at that, and where they fit in that and where they see it. (Child Protection manager).*

Another aspect of its appeal was that it was seen by several to *'reframe' the position of the worker* in a way that was helpful:

*The first thing that really struck me was the sense... to a large degree, it is the client's responsibility for changing their own life. Again, we probably all know this, self-determination is supposed to be part of our understanding or insight or perspective, but really it ... struck home much more so throughout the whole two sessions ... I felt more like testing it out ... we tend to take it on ourselves, on our own shoulders. And I think the*

*pressure is always from other agencies for the social worker to do something. (Child Protection social worker)*

*I suppose the thing that challenged me was the whole assumption...that people cannot help themselves, that they don't have the resources. I think he brought that out quite well ... That we call ourselves the helpers and take the helping role and that they are the helpless, in the helpless role. And that they present and we solve ... it's just the way in which the whole helping profession is set up. (Medical social worker)*

### ***The appeal of 'brief' and pragmatic practice***

17 of the respondents mentioned its time-limited, brief or focused qualities as appealing. For intake workers or those who carried out primarily short-term work this was an obvious factor. In one area where an intake system was being established, three workers were sent to the course with the aim of incorporating SFT into the new system.

*I suppose I thought it might be relevant to intake work ... it was brief ... it was sort of very focused, there was a clear beginning and an end to it. (Child Protection social worker)*

It also interested those in other services, such as child psychiatry, where long waiting lists were a feature:

*... the context from where I was coming from: where we have long waiting lists and a lot of complex family problems – the idea of short-term work in order to move people on and would address the waiting list issues seemed very attractive. (Child Psychiatry manager)*

### ***What particularly interested you about the concept of it?***

*I think the briefness of it more than anything else because of my high potential caseload, I actually can't get into more long-term work ... I suppose the fact that there were specific techniques struck me – very specifically, the miracle question, the scaling and that the whole thing was so practical ... unique, very definitely unique. (Solo Therapeutic worker)*

A more general aspect of the brief focus was the way in which this challenged the assumption that workers needed to remain involved for long periods of time with clients:

*I'd say the central elements would be about, I suppose, challenging the idea that you need to be involved with people for many years about a problem. (Child Protection social worker)*

*You might as well adopt a more positive approach given what you are trying to achieve and given the fact that a lot of clients don't come for four years or whatever. (Child Psychiatry social worker)*

The fact that SFT contained *specific techniques* was mentioned and emphasised again by many respondents, and for some it was certainly the central appeal of the approach:

*... certainly the techniques of the first interview when you meet someone and they are up to high-do and you are listening to them and being able to spot certain qualities and point them out to them. I found it very good from that point of view – the techniques. (Fostering social worker)*

*I found that it was very specific in the sense that there were stages of questioning ... In a sense it really was very structured ... and very, very useful ... (Child Protection social worker)*

*... the time limit ... and I took away the point about starting where someone is at and making realistic steps – helping them identify clear steps ... the task of the worker was to help them identify the steps as to how they might achieve that. (Child Protection social worker).*

### **Hope/Optimism**

16 respondents referred to the element of hope, or optimism and related these concepts both to clients *and* workers. The concept of hope was described in two ways: the extent to which the focus on positives and strengths motivated *clients* to continue looking for solutions; and the importance of hope on the part of the *worker*:

*When I think of brief therapy ... optimism really is what comes to mind, and enhancing the clients' own abilities and powers to turn around their situation. (Child Protection social worker)*

*I did think the thing that was very heartening was the belief, the belief underlying it was that people can change...so there was a hopefulness about the method and the feeling that people are probably doing some of the things that they need to do, but they are just not actually often enough or getting credit for it ... I found that part of the therapy very heartening and very practical as well. (Child Protection manager)*

*I liked the element of hope ... whereas what I would have felt before was that there are elements where we sort of sign people off because of their life – just said: less chance, difficult background, difficult childhood, dreadful experiences ... [Now I think] can we turn them around, can we help them make their lives more useful to them' (Child Protection social worker)*

*[Before] I would have asked them a lot of questions about all the problems and the more they give you, the more it became more hopeless for me as a worker ... I knew that clients had enormous strengths and coping skills but I never really asked them about it, you know? (Voluntary Agency manager)*

*I took away a lot of hope for the workers – hope that they could actually do something. I suppose it just seemed to me an approach that could work ... that it was positive, very hopeful really and a way of passing on that hope in a realistic way. (Child Protection social worker)*

The impact of the hopefulness of the approach was described by one in relation to how he felt after the training:

*I think that I felt energised, literally, and that was what I wanted to do – go straight away and get down to it, you know ... it (SFT) was different in terms of energising, yeah, and that was the one thing in leaving there. I was much more positive, that this is actually, that I think this is going to work ... This was very different in the emphasis on the energy that was there, you know. (Child Protection social worker)*

Another spoke of the contrast between SFT and other ways of working:

*... when you consider the ... deflationary effects of psychoanalysis and those approaches ... it addresses the whole idea that things are temporary and if you can solve them here and now well you might be able to solve something in the future ... I think that's also extremely useful in terms of social work because I think we are inclined to get involved with that baggage which uses up our energy which could be used more constructively. We get drawn in. (Child Protection social worker)*

### ***The approach as ‘different’ and ‘new’***

The approach was described by over a quarter of the respondents (14 out of 52) as ‘different’ or ‘new’:

*A different point of view, a new approach, to working with families who were, you know, really long term or chronic difficulties ... that’s what interested me – a new approach.* (Child Protection social worker)

This difference was described by some respondents as ‘refreshing’, whereas others saw it as ‘challenging’. For many the perceived difference was that this approach appeared to offer the opportunity for the worker to work positively with clients and build on strengths and resources:

*I certainly think it’s a challenge and it’s something different to what we’re traditionally being taught, you know that it’s not radical or new in any way but it’s just maybe putting some boundaries around what we already practise and the values and the principles that we already have ... and making it more workable ... you know that they are not just principles and values out there, it’s actually bringing them into practice.* (Child Protection social worker)

*I think it’s a bit radical in its approach – that you’re approaching the thing from a totally different way, a different angle in that you’re maybe allowing people to hear things in a different way.* (Family Centre social worker)

The approach was generally viewed as unique in this respect:

*... people, you know, when brief therapy is actually introduced, people would say: oh, but sure that’s very like the other, but the reality of the matter is that I don’t know ... whether any other approach, or even just the way that people work in the field – with a very problem-oriented sort of approach ... it really does actually contrast at the end of the day with what I would be familiar with in the social work field in terms of how people approach things ... It would really [be] the complete reverse ... if the approach is actually followed through consistently, it’s actually quite a revolution almost, you know? In terms of approach.* (Child Protection social worker)

### **SFT had little or no appeal for some respondents**

For 6 respondents, all working in different locations, the approach had little or no appeal. Their lack of enthusiasm appeared to be related to their satisfaction with existing approaches, their views of social work, their own levels of optimism about what social work could achieve, and the specific work contexts in which they were located.

- Two medical social workers who were engaged in long-term contact with clients who were either elderly, chronically disabled or chronically ill, were critical of the method for its superficiality: *‘it was a little bit slick ... very sort of pat. Here’s problem A and the solution, and we know that it doesn’t work like that really’*; and had problems seeing it fit into their current work:

*... a lot of time would be spent counselling ... I thought it (SFT) might be good because it was brief, and a lot of the counselling can go on and on ... but it’s not pertinent to where I work ... it wouldn’t have a relevance for a lot of our patients ... choices are limited.*

In their view there was no such thing as a ‘quick fix’, although one of these two workers indicated that the training had raised questions for her about the long-term, open-ended nature of the counselling she was offering.

- The fostering worker and fostering team leader, from different areas, shared a common belief that SFT did not fit into fostering work because: *‘in the assessment end of things ... what you are doing is taking kind of semi-histories’*; fostering applicants are offering a service and are not viewed as clients.

Both workers also disliked the set model approach and appeared to rely instead on a mode of working which privileged intuition:

*... bits of information change your practice or come back to you in a situation where you’re looking around for answers and bits of it may come in there ... as a total approach, as an intervention, I wouldn’t have thought of it again. But that’s to do with the job I’m in.*

- The two community care social workers, both newly qualified, seemed to regard SFT as unrealistic. One said *‘as an approach, I felt: oh, my God, this is too good to be true and nothing really works. Total pessimist – I’m just in the door and I’m a total pessimist.’* The other appeared to share this pessimism but also lacked confidence in her ability to apply SFT: *‘I was a bit sceptical really about how I could use it in my own practice ... it just sounded so good and worked so well for him but ... I just thought asking some of my clients: “what would happen if the miracle occurred?”’* The sense that emerged from their accounts was that as newly-qualified workers, they felt rather helpless and lacking in confidence about what they could do to achieve change which led them to believe that SFT would not work.

Table 12: Early Rejecters of SFT

<b>Location</b>	<b>Years qualified</b>	<b>Type of Social Work</b>	<b>Perception of SFT</b>
Medical social worker One	Over 5 years	Long-term disability	Slick; Americanised, repetitive
Medical social worker Two	Over 15 years	Long-term illness	Too good to be true; disliked techniques
Fostering social worker	Over 20 years	Fostering assessment and support	Dislike of set model approach to practice
Fostering manager	Over 20 years	Fostering and family support manager	Dislike of set model approach
Child Protection worker One	Newly qualified	Long-term team	Too good to be true
Child Protection worker Two	Newly qualified	Intake team	Too good to be true, limited expectations



From their accounts, it was evident that decisions were reached relatively quickly that SFT was not of use to them. They appear to have decided by the time that the training course had ended to reject the approach – they were therefore *early rejecters*<sup>205</sup>.

For these six practitioners who rejected the approach at an early stage, rejection did not automatically mean that the short course had no effect, and the more covert or subtle effects of the SFT course on some participants will be outlined in the next chapter.

## CONCLUSION

SFT was perceived by the majority of respondents as compatible with the values and ethos of social work. It was viewed as practical and accessible; as more ‘positive’ than other methods in its emphasis on the client’s perspective and client abilities, and its hopeful and optimistic stance; and in being brief and goal-focused in its orientation. For many it was a combination of these perceived characteristics which appealed to them.

The accounts outlined above demonstrate the extent to which respondents were explicitly and implicitly comparing SFT, not only to existing practices, but also to their interpretations of the social work ethos and role.

For many, SFT appeared to offer a way of working which was consonant with the social work values of self-determination, inclusiveness and an appreciation of client strengths. SFT was also seen as accessible and less complex than other therapies, suggesting that for most it was perceived as simple to understand and use. The specific techniques were mentioned time and again by respondents as particular features of appeal and four specific interventions were the elements highest in the recall of respondents. SFT was seen to provide specific tools practitioners could use.

SFT’s appeal as a ‘new’ and ‘different’ approach with ‘brief and ‘pragmatic’ qualities was not as widespread as the already cited features, but was still significant for over a quarter of respondents. This suggests that, although its fashionability and the positive accounts of near-peers were influential in motivating individuals to attend the training course, their assessment of SFT was then more subjective but also pragmatic. Individuals considered its relevance to their current work premised on a critical assessment of its perceived characteristics such as relative advantage, compatibility and complexity. Those who disliked it cited the formulaic nature of SFT and also some of the specific strategies. They also indicated that such a theory was either not relevant to their current work (and that other approaches or frameworks were preferred instead) or that they did not believe that the changes as claimed were possible.

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<sup>205</sup> A new category, not derived from Rogers’ original theory.

With the exception of those who made early decisions to reject the approach, the assessments of 'new-comers' can be considered as *provisional* judgements reached during exposure to the approach on the training course but prior to being tested in the real working conditions the respondents returned to after the training course. In the case of 'returnees', they were basing their assessments on earlier training plus subsequent experimentation.

## CHAPTER TEN: AFTER ‘THE DUBLIN COURSE’ – EXPERIMENTATION, CONVICTION AND DOUBT

### INTRODUCTION

It is in the transfer from a short course back to social work practice that the transition needs to be made from ‘*knowing-about*’ an innovation to testing the approach and the skills of the practitioner in ‘*knowing-how*’. In practice experimentation, the social worker translates (Fook *et al.*, 2000) formal or ‘public’<sup>206</sup> knowledge into living knowledge through personal use of it in practice (Eraut, 1994). It is only after the return to practice that a grounded assessment can be made by training participants of the value and perceived characteristics of a specific practice innovation such as SFT.

In this chapter, the experiences of the respondents as they moved back into practice with the innovation will firstly be described in Part One, followed by an overview of the movement in the innovation-decision process made by respondents in this study in Part Two. Case examples provided by respondents during interviews are included in the Appendices, in Appendix D.

### PART ONE: PATTERNS OF EXPERIMENTATION

#### Characteristics of an Innovation

Rogers (1995) suggests that, in addition to the three perceived characteristics of innovations: relative advantage, compatibility, and complexity; all of which can be notionally assessed while on a short course prior to a return to practice, two others exist which will be of influence in determining the individual’s attitude-formation to an innovation: trialability and observability.

*Trialability* is ‘the degree to which an innovation may be experimented with on a limited basis’ and *observability* is ‘the degree to which the results of an innovation are visible to others’ (Rogers, 1995: 16).

Both characteristics pose some difficulties in the field of social work practice. The findings from Chapter Three suggest that the ‘trialability’ of practice innovation is hard to predict or plan for, because of the indeterminate and uncertain nature of the problems which individual social work cases pose and the limited extent to which workers are able to plan their action (Parton, 2000; Schon, 1983; DHSS, 1978).

The extent to which practitioners may be able to experiment systematically with a practice innovation is open to question, particularly a therapeutic approach which might only have selective

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<sup>206</sup> Public knowledge is defined by Eraut (1994) as that which can be codified and formally taught.

applicability given the multi-tasked nature of social work practice in many contexts. This may be especially true for many of the practitioners in this study who operated in front-line child protection posts rather than specialist or therapeutic services.

The concept of ‘observability’ is also problematic given that social work is often a ‘invisible’ activity (Pithouse, 1987) seldom witnessed by people other than client and worker.

#### **PATTERNS OF EXPERIMENTATION**

Table 13 provides an overview of the patterns of experimentation of the entire group of 37 newcomers across settings. It is followed by sections dealing with each of the sub-groups.

<b>Setting<sup>207</sup></b>	<b>Did not try out</b>	<b>Tried once &amp; abandoned</b>	<b>Tried &amp; aimed to continue use</b>	<b>Total number (n=37)</b>
Child Protection	7	2	10	19
Medical	3	2	0	5
Fostering	3	2	2	7
Therapeutic	0	0	5	5
Other <sup>208</sup>	0	1	0	1
<b>Totals</b>	<b>13</b>	<b>7</b>	<b>17</b>	<b>37</b>

Table 13: Breakdown of Patterns of Experimentation (n= 37)

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<sup>207</sup> Practitioners and managers were kept separate in this analysis as it became apparent from the data that the managers influence was significant in supporting or extinguishing the innovation; the child protection workers are those who were operating within the community care frontline services; the therapeutic workers were those who were in settings where their role was primarily therapeutic or preventative in nature and where they did not hold any frontline child protection responsibilities themselves: these included workers in child and adult psychiatry; staff counselling and family centre work.

<sup>208</sup> The ‘other’ who tried the approach once was in residential care, who did not easily fit into any of the other categories.

### **Profile of respondents who did not ‘try out’ the innovation (n = 13)**

13 practitioners and managers did not attempt to use the approach at all, or to encourage its use – just over a third of the total of 37 ‘newcomers’. Yet as will become evident, not all of these were necessarily rejecters of the approach. They had merely made a decision not to try it out in current conditions.

12 respondents were positive about SFT in general, but expressed some reservations or had difficulty in seeing its relevance for their direct work. Only 1 of the 13 respondents had definitely hoped to use it but was unable to do so because of intervening personal factors. There were indications that the decision (not to carry out a trial of SFT) was influenced by two factors:

- (a) individual interpretations of the social work role; and
- (b) practical constraints which were perceived to exist in some settings.

Table 14: Respondents who did not use SFT at all (n= 13).

<b>Setting</b>	<b>Location</b>	<b>Years qualified</b>
Child Protection social worker	Area G	13 years
Child Protection social worker	Area G	1 year
Child Protection social worker	Area D	1 year
Child Protection social worker	Area D	3 years
Child Protection manager	Area C	14 years
Child Protection social worker	Area C	4 years
Child Protection social worker	Area E	1 year
Fostering social worker	Area I	30 years
Fostering manager	Area D	22 years
Fostering social worker	Area F	28 years
Medical social worker	Hospital A	20 years
Medical social worker	Hospital A	12 years
Medical social worker	Hospital B	15 years

### ***Breakdown of responses from those who did not attempt to use the approach***

#### ***Child Protection Setting***

‘Overwork’, the ‘crisis’ driven nature of community care social work, the lack of relevance of ‘therapeutic’ models for frontline social work, and the investigative role of the child protection

worker were all cited as factors by the 7 respondents (6 practitioners and 1 manager) from child protection settings who did not go on to use the approach. 5 of the 6 practitioners were relatively inexperienced.<sup>209</sup>

The general consensus was that, because of the conditions that existed in these areas and the nature of the work, SFT was not applicable.

*... at the time, given the flux that we were in....in the area here, just the idea of getting that orchestrated or organised here about anything just seemed so monumental, that it just didn't seem practical at the time or a reality, you know? ... the difficulty of just taking that time out to plan when the weight of the work to be done was so enormous.*

At least 3 of the workers appeared to be demoralised both by the complexity and nature of the work they were doing and by the lack of resources to help families and children in need:

*There is a sense of frustration ... that you could be doing something like that (SFT training) and you come away energised....and then other things take over. At this stage it's difficult not to feel pessimistic about it, the kind of pressures. My own sense of being on the team here is that things keep overtaking you all the time. The pressures are everywhere - the whole issue of placements - the lack of them. I suppose that's the real killer. There are layers of it in a sense - at one level you have all this unallocated work, on another level ... you have your caseload - there are so many other elements of that, that you are not in control of ... I think that people are chasing their tails quite a bit of the time ... in terms of being more planned and having the kind of space and time both to go through that work and plan it ... that's not there'.*

All six workers shared a certain pessimism about whether change-work was possible and none appeared to see as possible the concept of the social worker in community care being an *active change agent*. As indicated by the respondent quoted above, they did not feel in control of their work. Ideally, they might want to adopt a new innovation like SFT but realistically that would mean spending time and creating space to plan and implement a piece of work using SFT. In the words of the worker above, there was no time for that because everybody was too busy reacting to situations rather than planning responses.

Four workers retained an interest in SFT but felt that lack of support or interest in their teams had deterred them from trying it out: *'there has been very little follow-up and there has not been a huge amount of interest shown'*.

One worker wished to pursue SFT and was involved in establishing a (short-lived) support group in her area but cited conditions in her workplace and in particular the reactive nature of practice at that time as factors in her inability to implement the approach: *'everybody is getting sucked into the local crises in the areas ... I despair'* which also appeared to have had a demoralising effect on her confidence level as a practitioner.

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<sup>209</sup> 3 had qualified the year before, one had three years experience and one four years. The sixth, a specialist worker for youth homelessness, was extremely experienced.

*The managers' perspective:* In two health board areas, the evidence suggests a collective negative attitude towards SFT. Two area team leaders (one for child protection and one for fostering) who attended the Dublin course but made no attempt to encourage use of the approach were from the same areas as two of the three workers cited above, confirming clusters of non-use.

While both managers liked SFT in a general way, neither of them saw it having such a direct relevance to the work of their teams that they were motivated to encourage its use. Both also mentioned that their own inability to try the approach in practice left them feeling less confident in their skill to supervise its use.

There were also indications that one aspect of the approach which interested them was the level of input that clients would have:

*It was a bit about getting clients to do the work ... to look at what was happening in their lives ... try to analyse themselves what they are doing, and that you can help them to do that;*

*I thought, this is different ... I think it does need some sort of shift in my thinking....changing the focus of being all things to all men ... It is really where the client is at that you are addressing... It may not be what you agree. It may be that you say that this is only a part of it and unless we do x, y, and z, this is not going to change ... and I think that's where the shift is really.'*

For the second manager, this aspect of the approach appealed to her but for reasons which remained unclear, the 'shift' that was needed did not take place and no momentum for change survived the transfer back to working realities.

### ***Medical settings***

Three out of five medical social workers did not go on to use SFT. One had been enthusiastic about the approach and keen to try it following additional training, but was unable to follow through due to unexpected personal factors. This worker differed from the other two medical social workers in that she described her role in terms which fitted the emerging category of 'active change-agent'<sup>210211</sup>.

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<sup>210</sup> An active change-agent is one who is able and willing to consider using specific strategies or techniques in the process of helping people and achieving change.

<sup>211</sup> Her description of her work necessitates a detailed footnote as it illustrates many aspects of the hopeful, active change-agent. She spoke of her work in rehabilitation involving both the patient '*and the changes that that would involve both within the home situation and for themselves...we would look at people who are carers having a break and we would use some of the beds for respite for those carers...and I do home visits with the OT...in the hope that we are looking at the whole family situation and not just the patient in isolation...With the patient it would be the frustration at not being able to do what they were capable of prior to the [hospitalisation]. Sometimes there would be a lack of understanding of the patient's point of view...So work would be on an individual basis with the patient but also trying to assist the families to understand...and I would often enlist the help of my colleagues in, say the physio. Being able to take the family into the department and show them physically what the patient has achieved while*

The other two workers had been negative about the training, the presenter and SFT, and for both of them SFT appeared alien and contrived. Neither saw it fitting into their established way of working: for one, this was to do with her interpretation of her role which necessitated supportive casework over a long period<sup>212</sup> in a style of practice I have termed ‘*passive witness*’ (passive in contrast to active change-agent). The other worker disliked the way in which specific SFT techniques skirt around a problem rather than focusing on it directly. This worker, who approved of the ethos of SFT (in particular the emphasis on positives and helping clients to find their own solutions), also implied that adoption of the approach required a shift in thinking which did not have time to occur on the course itself:

*There was going to be....a brief therapy support group....or something like that, and I thought: yeah, that is the way to actually go about doing it. It comes back to my other point about owning - if I could get more at ease with it.*<sup>213</sup>

### ***Fostering settings***

The remaining 3 respondents who did not go to use SFT were 2 area-based fostering social workers and 1 area-based fostering manager. All were extremely experienced. One had been sent on the course by a manager, had little interest in new models of working and no intentions of trying SFT out in practice; another who could not afford two days away from work had attended for one day of the training because she thought it sounded interesting, which is suggestive of a desire to ‘hear about’ rather than to learn the approach.

None of them viewed SFT as having a relevance for their current work. Their main priority in fostering work, given the crisis of lack of placements<sup>214</sup>, was recruitment and assessment of prospective fostercarers. Fostering applicants were not viewed as clients and so theories of helping were not seen as appropriate; instead practitioners rely on assessment schedules. The priority for these workers was their function: to recruit and assess prospective foster carers. They therefore primarily operated as *agency functionalists*<sup>215</sup>. They were more focused on agency role and agency

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*they have been here, trying to dwell on the positives of what they can achieve and what they are able to do.*

<sup>212</sup> The ‘passive witness’ approach indicates a style of practice which empathises with clients suffering, which looks at ways to support them with their difficulties but which does not encompass a view of the worker as an active change-agent using specific strategies or interventions.

<sup>213</sup> The training input did not feature any examples of the approach being used in medical settings which may have made it more difficult for medical social workers to envisage its application. Given the strong impact on other trainees of live or videoed material which resembled their own cases, this placed the medical social workers at a disadvantage.

<sup>214</sup> See Chapter Two for details of the problems regarding the lack of placements in the area at the time of the study.

<sup>215</sup> Functionalists concentrate primarily on fulfilling their agency obligations and are similar to ‘functional bureaucrats’ described in Compton & Galaway (1994) as professionals ‘who just happen to be working in a social agency’ (p. 200). The social work ethos and welfare of clients do not feature in their accounts.



priorities than other fostering workers who had a broader view of their role which included therapeutic work in supporting placements and dealing with difficulties as well as recruitment.

While they thought that SFT *could* have a role in supporting fostering placements in difficulty, none of the three made any effort to pursue this further. However one, the fostering team leader, had purchased books on SFT at the Dublin course and indicated that she would like to review its usefulness if she were to change role. In relation to the SFT approach she said quite clearly that while she did not see a role for it in her existing work, she had not rejected it: *'I think now that if I were to move and work with a different group of social workers, that I would look at it again'*.<sup>216</sup>

This feature which was also evident in other accounts suggests that some social workers may 'store up' potential tools for future use or review, indicating that innovation –decision processes in social work may extend over a long period for some.

### Participants who tried SFT once

Table 15: Participants who tried SFT once following training

Setting	Location	Years qualified
Child Protection social worker	Area A	6 years
Child Protection social worker	Duty Service	20 years
Child Protection/ Fostering <sup>217</sup> social worker	Area F	29 years
Fostering social worker	Central Unit	21 years
Medical social worker	Hospital A	6 years
Medical social worker	Hospital B	7 years
Res. Care manager	Area B	7 years

A total of seven respondents tried SFT once and then stopped. Most of this group liked the approach but had concerns about two issues:

*firstly, would it fit into their practice?*

<sup>216</sup> This comment raises an intriguing question: was she constrained by the actual workers she was supervising or by the team function which was one of family support and fostering work? The answer is not evident in the remainder of the interview transcript.

<sup>217</sup> This respondent had been employed in a child protection role for six months following the training, after which she transferred to a fostering post in the same area.

*secondly, did they have the skills and confidence to pursue it?*

All 7 had some doubts in relation to one or both issues but were of the view overall that they'd 'give it a try'. Five of the six practitioners went on to try it without support from colleagues or supervisors and their accounts indicated that they had run into difficulties while using it. In two cases the work was interrupted when either the worker or client transferred after several sessions. In both cases the workers remained unclear about the outcome for the client, hindering assessment of the innovation in relation to its 'observability' (Rogers, 1995).

### ***Child protection setting***

The three area-based workers described applying the approach in difficult child protection cases as a last resort, when they had run out of ideas, suggesting partial support for Harrison's (1991) thesis that practitioners only move to adopting a creative heuristic search for a new solution after their 'tried and tested' strategies fail.

In one situation, the use of the SFT approach in the worker's opinion did help the mother [of a child in difficulty] to identify some positives in the child and facilitated the worker's engagement with the mother so that '*she didn't mind me calling*' but the father remained hostile to the worker and rejecting towards the boy. In this case the worker was keen to continue using SFT but she transferred to a fostering post shortly afterwards and the opportunity was lost. She did not consider SFT relevant for her new work in fostering.

In another area-based case, the worker used it with a mother who was seen to have

*... very negative views of the children – there were medical difficulties and behavioural difficulties ... trying to look at more positive aspects of the children ... trying to move herself to see things in a different light ... she found it really difficult to be constantly stopped in the negative thing ... and she ended up not coming back after the first two sessions'.<sup>218</sup>*

The worker was unsurprisingly nervous about subsequent use of the approach. His interest in it remained but he was unwilling to try it again without the support of a co-worker familiar with the approach<sup>219</sup>.

The third child protection practitioner who tried it once and then stopped attended only one training day. Her understanding of the approach was therefore partial. She experimented with the Miracle

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<sup>218</sup> The view could be taken that this was a 'misuse' of the approach in that positive reframing alone is likely to lead to clients feeling that their problems are being minimised or that they are being patronised. Another respondent in this study experienced in the use of the approach speaks with disapproval about SFT being interpreted in this way.

<sup>219</sup> At the time of interview, this practitioner had another case identified that he wished to use it in and was hoping to recruit a co-worker from his team.

Question<sup>220</sup> in another area of work she was engaged in – that of marriage guidance counselling (Appendix 4: 1). She was pleased with the results of this and continued to draw occasionally on the Miracle Question in her work with adolescents, primarily to assess their view of a situation. Her initial trial use of SFT seems to have been important in confirming for her the potential benefit of the approach but she said she needed to engage in further training before she could fully assess the approach.

### ***Fostering setting***

One fostering worker tried SFT out once with some success but indicated that she had not continued with it as a complete approach. Following the training event she had made some attempts to use it: *‘very actively, very consciously’* and she gave a detailed case example of one specific case where she used it (Appendix 4: 2). Her observations underline the difficulty social workers have in knowing what causes change when change occurs. In this case, although the initial problem (bedwetting) had greatly improved, she was wary of claiming credit for this:

*Now I can't say it was as a result of that [SFT] but since then I have been trying to get her to react differently to it and I think that was at most what I thought we'd be able to achieve ... and in fact he is wetting a lot less now.*

She had particularly liked the philosophy of inclusiveness: that *‘you put it back to the client to come up with what they thought they might be able to work with rather than us going in and preaching’*. Like some other experienced respondents already quoted, this practitioner was comfortable and confident in borrowing ideas in a ‘magpie’ fashion rather than wholesale adoption of particular methods: *‘I didn't see that I would take it completely as a method, but I'm like that about most things. I take a bit of this and a bit of the other and see what it goes like’*.

However, this magpie approach did not preclude the need for an active conscious effort to try it out in a formulaic way first. The difficulty in establishing whether the use of SFT had led to the improvement in the problem, coupled with an experienced practitioner's preference to use a ‘magpie’ approach to the use of theory, and her belief that inclusiveness was a core aspect of her practice anyway (*‘I'm permanently trying to involve them’*) led her to conclude that SFT was not really an innovation in itself. The training had an impact: *‘I suppose I've been influenced a bit to be more inclusive’* but she saw this as a *‘continuance and a development’* of her practice rather than an innovation.

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<sup>220</sup> She demonstrated what was a common feature among the more experienced workers: the ability to collect what are perceived to be applicable pieces of a theory in a ‘magpie’ fashion and apply these in seemingly effective ways.

### ***Medical setting***

Two medical social workers tried SFT once and both indicated some philosophical struggles with the approach. For one, the notion that problems could be resolved in short-term work was antithetical to her belief in long-term work and she also appeared uneasy with the active role that the worker took. The other did not see it as relevant to a lot of issues she dealt with, where casework focused on ‘insight development’ was needed. They also appeared to dislike the notion of adopting a particular approach and applying it systematically.

For both, use of the approach was somewhat half-hearted (Appendix 4: 3) and following limited experimentation, both reverted to their established frameworks for practice, which privileged a more passive nurturing and supportive change-agent rather than an active change-agent role<sup>221</sup>.

### ***Residential child care setting***

The final respondent who tried the approach once was a manager of a residential care unit who used elements of SFT with one child just after the Dublin course (Appendix 4: 4). For this manager, experimentation took the form of combining some elements of SFT (identification of exceptions and slow tracking of the positives) with a behaviour modification regime. The value of adding the ‘*positive*’ focus was that it took the ‘*bite*’ out of a strict behavioural regime, but this manager was also clear that he already had a prevailing ethos: *‘for this sort of children’s home ... you prefer to have something that is more attachment based....that is more relationship, more child centred really [than behavioural work]. I felt it [behavioural work] was an approach that was a bit brutal, you know?’*

This manager did not go on to further experimentation with the approach. Reasons cited were: the pressures of the ‘start-up’ period (as the home had just opened when the training started); the lack of a dedicated training programme for residential workers; the manager’s view that it would only really ‘take root’ in such a centre if the staff took an interest and had unit-wide training; and his consequent reluctance to ‘impose’ it on them. It should also be noted that this manager attended the training at the suggestion of his line manager, and so personal motivation for engagement with the approach remained weak.

The manager’s prevailing orientation, towards a relationship or attachment based practice, with behavioural approaches to be used as a second resort when the first failed, doubtless also influenced his attitude towards the introduction of a new practice method. If what he was doing was working, then why change?

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<sup>221</sup> Both approaches can of course be experienced in a range of ways by clients, depending on the fit between what the client is seeking and offered, and their experience of the encounter.

### **Practitioners who tried out and continued using SFT**

A total of 17 respondents (out of the 37 newcomers) tried out SFT after the training event and reported that they had continued to draw on it in practice following initial experimentation. 10 were in child protection settings, 2 in fostering and 5 in therapeutic settings. As will become evident, not all of them reached Stage 4 in the innovation –decision process. For some their assessments of the benefits of using the approach remained provisional so that they remained at Stage 3 of the process (experimentation and review) rather than confirmed adoption of the approach by the time of interview 12 – 16 months after the training event.

### ***Breakdown of the participants who continued using the approach***

Table 16:Child Protection

<b>Location / role</b>	<b>Yrs. qualified</b>
Area J practitioner	3 years
Area H practitioner	6 years
Area H practitioner	3 years
Area A manager	13 years
Area A practitioner	2 years
Area A practitioner	9 years*
Area D practitioner	1 year*
Area D practitioner	1 year
Area C practitioner	4 years*
Area B practitioner	2 yrs.

\* indicates those practitioners who remained at Stage 3 rather than progressing to Stage 4.

- The nine practitioners and one manager from child protection teams who continued using SFT in health board area offices came from six different area offices.
- Three were from Area A where there was already an established interest in the approach; and one from Area B where there was also a climate of interest<sup>222</sup>.
- Seven of the ten indicated that they had sources of support for their use of the SFT approach within their agency.
- The other three (two from Area D and one from Area C) were unsupported in their experimentation with the approach. They came from area offices where most of their

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<sup>222</sup> The cluster of interest already in existence in Area A is demonstrated by the numbers who attended from that area. The Senior Social Worker in Area B was also the course organiser.

colleagues who had attended the training had either rejected the approach or had abandoned use after initial experimentation.

- The majority were recently-qualified. Seven of the ten were qualified for 4 years or less, and only three were qualified over four years.

*Those who used the approach without the support of colleagues or agency*

The three practitioners who came from areas without a climate of support for SFT, indicate that their efforts to implement it in practice threw up difficulties. All perceived their working environments as problematic with descriptions of the crisis-driven nature of the work and the lack of time to plan what strategies to employ. They all left the course full of enthusiasm about the approach, eager to try it out and had followed up with experimentation shortly after. Two described their initial attempts to use SFT as a struggle which affected their level of confidence in themselves and the approach. One hoped to identify potential co-workers on her team with whom she could undertake joint work or joint support, but was unsuccessful in doing so<sup>223</sup>. She nevertheless persevered in trying out some of the solution-focused questions by herself (Appendix 4: 5) but with limited success.

For both practitioners, their interest in the approach had remained despite setbacks. One said: ‘I definitely see a place for it but we don’t use it enough and I think we see ourselves as moving from crisis to crisis’. They wished to implement it more fully in their practice but felt that in current ‘crisis’ conditions and without area-based support this could not be achieved. They therefore remained at Stage 3.

The third practitioner who used it by herself without support was, in contrast with the others outlined above, overtly wedded to the philosophy of the approach as much as to the techniques. She understood the approach to mean

*... that you’re helping the client to work towards a solution to their problems ... you are not imposing your ideas on the client ... it mobilises the client to think there is a solution so now how can I work towards it?...the social worker is there to help the client – to provide a positive environment to help the client ... the client’s skills and resources are being drawn up.*

This practitioner described how initially she was using the whole framework but that now ‘*over time, I would remember parts of it that I really liked and would have found applicable to certain*

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<sup>223</sup> Although another practitioner from this same area was experimenting with the approach at the same time as her, there was no indication from either of their accounts that an informal communication channel existed between them. It may have been that they were in separate geographical locations and different teams, but the lack of a communication channel between them resulted in both experimenting independently and feeling isolated in doing so. Both were newly qualified workers who had attended different social work courses. An unexplained issue is why these separate innovators had not found each other, and whether this reflects on the culture of this area where mental maps were not explicated and discussed or whether it was more to do with young inexperienced workers being fearful of exposing their practice to others.

*situations*'. She found that she was using it in particular with women clients: *'one-to-one with women who are ... experiencing personal difficulties in their lives with children in care, partners, families.'*

She also provided a clear example of how she was using it in practice which indicated that she was using it as a basis for empowering a client (Appendix 4: 6). Aspects of the approach that she particularly drew on were: future focused 'possibility' questions, emphasising the positives, reframing, scaling questions. This practitioner also spoke of the concept of hope which she felt SFT engendered and how important that was both for worker and client:

*It gives people hope. It gave some of my clients hope ... it pulls them up from chaos and it also pulls them up a bit from their pain ... one of the reasons that they are coming to you is because they are overwhelmed ... and they need to see a beacon or whatever. It sounds corny but they need to hear positive ideas and they need to know there is hope ... and to be able to see that there are solutions.*

Unlike other practitioners who did not feel able to sustain its use and who cited the absence of support as a factor, this worker felt that she had successfully incorporated it into her practice and was not actively seeking more support. She made a decision quite quickly about the usefulness of the approach; it appeared consistent with her underlying philosophy, and she had confidence in her own judgement to maintain it without external reinforcement. She had a strong internal locus of control (Baldwin & Ford, 1988) and a sense of self-efficacy (Quinones, 1997). As a newly qualified graduate, she was a sole exception in these regards.

#### *Those who used the approach with the support of colleagues and agency*

One recently - qualified practitioner came from an area where there was support for SFT at a higher management level but no evidence of line managers being interested in SFT. This practitioner voiced reservations about how the approach could be incorporated into child protection work and was worried about her ability to use it after only two days training. She said her opportunity to try out the approach came about through serendipity and chance:

*I used it, I used some of the principles fairly shortly after that [the training] in a duty interview ... I was wary of doing it but then I thought, no, I'm going to go with it because it was almost a duplicate scenario of what we had seen on the video [at the training] and as far as I know, it worked.*

For this practitioner, the opportunity to try out the approach (Appendix 4:7) was unexpected but because of the strong similarities between the initial presentation and the example she had seen on video on the training, her fears about whether she was equipped to use it were overcome. Coupled with this strong incentive from the training example, she perceived her work environment to be supportive of its use (*'People in the office are very open to anything that is going to work, and brief therapy has been seen as one of those things'*) even though she did not receive any planned support in its use. She reported that in one other case, following solution-focused work with a teenager in

fostercare, she received positive feedback from the fostermother (who rang her the next day and said: *'whatever you said, she [the foster child] came home with an entirely different attitude'*) which helped to consolidate her belief that the approach did work and her confidence in continuing to use it. Like many of the other successful sustainers who were not in overtly supportive environments she also expressed the wish for follow-up training.

The remaining 6 practitioners from child protection settings, who continued using the SFT approach after initial experimentation, were all in positions where they had active support for their implementation.

- The two practitioners from Area H planned its use together on cases, although there was no overt support at management level in this location.
- Three practitioners were all from Area A where there was support for the approach at Head Social Worker as well as Team Leader and practitioner levels.
- The practitioner from Area J who seemed to be working alone, had a colleague in the area who worked with her in planning the use of SFT in individual cases for some months between the Dublin course and the research interviews.

The practitioner from Area J had gone on the training because of the enthusiasm of an old friend for SFT; and had attended the introductory two days during which she already appeared to have made a provisional judgement about the approach and where it might fit in her practice:

*The impression that I got from it was that it would work with A particular problem. It was not the solution to the big, big problems or to get to the bottom of everything....[I felt it would be most effective with] people who have difficulty in coping or a lot of the kids we get in.*

The aspects of the approach that most appealed to her were related to hope:

*I took away a lot of hope for the workers – hope that they could actually do something...it just seemed to me an approach that could work ... it was positive, very hopeful really and a way of passing on that hope in a realistic way to the clients...letting them set the pace.*

Shortly after the course, she found an opportunity to use it and she implemented the approach in direct work with a child in care while at the same time involving the school (Appendix 4: 8). This practitioner continued to use the approach both in duty work with parents coming with difficult kids where she has found it useful 'some of them do need a referral to child guidance or whatever but some of them go away just having looked at how they actually can work with their kids'; also with some of her longerterm work, where she gave examples of using it in a variety of ways. She demonstrated confidence in her ability to use it in statutory cases although she acknowledged that it was more problematic in worrying cases:

*It's not as easy to use because you really have your statutory concerns and you have to be very, very clear about those ... you might be trying to use it a couple of times and nothing is changing but for the child to remain at home – these would be quite serious cases – something has to change drastically, so that's a bit more difficult.*



Nonetheless she felt it was worth trying it in such cases, and her continued reflection about SFT had confirmed her belief in it:

*... because I've since come up with the idea that people believe what they say rather than what they do. If they say it themselves, they are more likely to believe it. I also believe in, no matter how 'bad' a parent seems, there is something good there generally. And I know myself if anyone tried to lay down the law to me, I'd be telling them where to go so it is an approach that helps to pull people away from that to a certain extent.*

This practitioner's assessment of the approach was that it had a definite place in her work and she incorporated aspects of it very successfully into her practice. She used it as a model for change-work, and had formulated her role as an *active change-agent* incorporating therapeutic work. SFT was not her only approach and she indicated that with particular problems she would use different approaches or adapt the SFT model<sup>224</sup>. Like other successful sustainers, although this practitioner would have liked someone else in the area who would share her interest in the approach, she showed herself to be less reliant on external support, and can be said to have had a strong internal locus of control (Baldwin & Ford, 1988). She also appeared to enjoy a high level of autonomy in relation to her own work, even in those worrying cases where child protection concerns were high.

When asked what impact the approach had on her practice, she thought, on a scale of 1 to 10, that the impact had been between a seven and an eight, but that it would have been higher immediately after the training course as 'it does slip a little'. This practitioner was without doubt a confirmed believer in the approach: *'there is a lot of linking to it and a lot of hard listening to get the right questions back. It's certainly good, and I'm recommending it to everyone as an approach. It really works'* but as her account demonstrates this involves selective application in particular cases with a specific focus.

*The two practitioners from Area H* who attended the course together and then engaged in joint experimentation in SFT were child protection workers carrying out a combination of work: duty, intake and longer term casework with vulnerable families and children in care. One had prior exposure to the approach, while a student on an international placement, and he had elected to attend the full four days of the Dublin course; his colleague attended for the introductory two days only. There was an indication that one's prior experience and interest in the approach had influenced the other to attend the course, and was an important support for her:

*Having another member of the team who had done it previously and was quite enthusiastic about it as well certainly was a help because we went on later and talked a bit about it and tried to use it in one case we were working on together.*

Their interpretations of the approach had a common focus. One described it as:

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<sup>224</sup> One example of a necessary adaptation was in relation to the need sometimes to pay attention to history: 'Chris Iveson ... seemed to be [working with] a child with no information about the background. But with a kid that I've worked with for years, and foster parents that I've worked with for two years, you do need to listen and you have to try and incorporate the two'.

*... talking through things, in language and pushing them [clients] to consider things in different ways and to think positively about the problem, or not to talk about the problem but maybe reframe it ... [it] can actually help shift the way they live their lives. Quite a lot of energy is put into engaging the client and ... identifying their talents and resources;*

The other highlighted the following:

*I took away the point about starting where someone is at and making realistic steps – helping them to identify clear steps ... to change your focus and rather than looking at the pitfalls, to look at what has been achieved ... a sense of people having control themselves of where they started and where they wanted to go, and the task of the worker was to help them identify realistic and acceptable [goals] and to help them identify the steps as to how they would achieve that.*

For this second practitioner, her previous exposure to Marte Meo video training<sup>225</sup> appears to have already established a mindset which was sympathetic to the SFT approach:

*I did feel that it [SFT] fitted very much. I had done training a couple of years ago in the Marte Meo method ... and this philosophy or ethos of building on the strengths of people, or trying to find ways of moving forward, that this fitted very much within the kind of thinking.*

These two practitioners carried out a planned piece of work using SFT shortly after the Dublin course in a child protection case but focused its use on one aspect of the casework involved (Appendix 4: 9). Both workers judged it to have been effective and had continued to draw on it in their individual practice.

The issues of hope and optimism came up again, as both workers referred to the way in which using SFT and experimenting with a ‘new’ approach had influenced their stance as workers:

*The focus on the positive I would have found quite a key. It was useful for us to think positively because this was a family that was terribly bogged down in negativity and they were actually quite shocked when we would keep on reframing and going back for the positives ... it has had a positive influence on me [as a worker]. I’ve taken and gained out of it ... it has made me feel a lot more skilled and confident about being able to have a choice or a different way of dealing with situations. That sometimes, if lots of other things seem to be failing, you go back and say: ‘let’s try this’ ... it would have given me a boost in that sense.*

*There was a number of positive differences ... as workers, myself and my colleague really enjoyed trying it out ... it gave us a clearer focus and I think it also stopped us maybe getting into a more negative way of looking at things which I think was helpful to the Mum.*

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<sup>225</sup> Marte Meo is a video training technique developed by Maria Aarts of the Netherlands. It has similarities with SFT in that it focuses on identifying and emphasising exceptions in the form of positive parenting techniques and reviewing these with parents or foster parents. It was introduced to practitioners in the EHB region a few years before the SFT approach but was a similar innovation. The linkage by this practitioner of the two confirms Rogers’ point regarding ‘clusters of technologies’ consisting of ‘one or more distinguishable elements of technology that are perceived as being closely interrelated...In reality, a set of innovations diffusing at about the same time in a system are interdependent. It is much simpler for diffusion scholars to investigate the spread of each innovation as an independent event but this is a distortion of reality’ (Rogers, 1995: 15).

As with most successful sustainers, the process here was one of a deliberate planned trial of the approach, an outcome that was considered effective, following which each incorporated it into their individual practice, and its use became less conscious and more intuitive. One said his usage

*... has slipped in the sense that I would rarely with the same level of enthusiasm go out and plan a case. I would find myself more often using some of the skills within the practice or the idea. And I do that without almost having to think about it now – it's part now of my language.*

Both indicated that they would welcome some refresher courses or health board support groups to keep the ideas and theory alive but also appeared content with the level at which they had incorporated it into their practice. Neither of the practitioners referred to their manager(s) as either supportive or not in relation to their use of SFT, but from their accounts it appears that they had a relatively high level of autonomy in deciding how to work with particular cases.

*The three respondents from Area A* consisted of one recently arrived team leader<sup>226</sup> and two practitioners. The team leader had the course suggested by her new manager but had also established that this was a method already in use in the team and so had some independent motivation to learn about it. The two practitioners attended the course of their own volition. One specified that she was curious about the approach because it was being used by peers; the other said that he was initially negative, despite positive reports from peers, because he thought of it as another fad doing the rounds but decided to 'go along and see what it's like, anyway'.

All three formed positive assessments of the approach by the end of the course and began to use it in specific cases. Each identified several features of the approach of particular appeal: the Miracle Question, scaling, identifying and amplifying exceptions and the overall positive focus of the approach; the belief in client's strengths and abilities and the establishment of hope on the part of both worker and client that change was possible:

*I came away with the feeling that the approach would say that first of all the solution rests with the client. They are the authors of their own destiny. And I think that we all accept that or that we all know that but in the working out of it, making people ... look at what they are doing and trying to implement it - the belief that they can do it for themselves –is very real, in a way that perhaps is not true of any other methods. (Team leader, Area A)*

The Area A workers gave accounts which indicated that during and shortly after the course they were deciding selectively where it might be appropriate to use it and where it would not. The team leader was most cautious about where it might be applicable. She found that it worked best with children and teenagers and that is where her team had implemented it most. She thought it was more difficult to use with families and in multi-problem situations although she was aware that members of another team in the same area were using it in such contexts. She was also dubious about how equipped workers were after a short training input:

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<sup>226</sup> Qualified 13 years previously, the newly appointed team leader had worked in another setting for most of this time.

*It needs a lot more training and I also think that people need to have a wide range of skills before they come to it ... I feel myself that it is not as simple as Chris [the trainer] makes it out to be, it's not that simple [for adults] after going for years looking for help.*

Nonetheless she gave several examples of how she had coached and supervised workers who used it in particular cases, and how effective SFT had been, particularly when the wider system (such as schools and other professionals) were also informed about and engaged in supporting the SFT approach. Her existing systemic perspective clearly influenced her way of working as she was one of the few respondents who did incorporate work with other agencies and professionals within the family-child protection system. She also believed that practitioners needed a knowledge of systemic thinking to draw on SFT effectively, a belief shared by one of its originators.<sup>227</sup>

The more experienced practitioner from this area said he felt energised after the course: *'it was different in terms of energising and that was the one thing in leaving there. I was much more positive that this is actually, that I think it is going to work'*. He had some clients in mind with whom he aimed to use SFT straight after the course. During the training course: *'particular families were going through my mind and I was just thinking I'd like to try that with this or that person ... originally the families that weren't shifting and I was finding it difficult to shift them'*. He did not co-work any of these cases but this appeared to be his own wish to 'try it out' himself first: *'I never used it with another person, co-working. And that was to do with staff availability at the time, the way things worked out. Probably a bit was to do with me, wanting to try it out on my own first'*.

He provided a detailed case example of successful use in a family situation where marital difficulties were a central issue and where he worked with the couple alone; in other cases he used SFT where interactions between parents and children were difficult (Appendix 4: 10). In all, it was the identifying of exceptions, the description of a preferred future and the slow tracking of how this could be achieved on which he most frequently drew. Although both he and the other practitioner from this area described their initial experimentation as quite exhausting, he also described in vivid terms the impact on him of his first 'success':

*... the first thing I noticed after the sessions that went on with that particular family, I walked out of that family feeling brilliant. For me personally feeling totally relieved of responsibility in terms of what they were doing, and felt that now they are actually participating and taking control of their own lives and will change things if they want to change things ... I just felt, I am no longer carrying this, literally.*

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<sup>227</sup> 'Particularly when solution construction gets stuck, the therapist cannot depend on the method alone to get unstuck. At those times it is important to remember that an understanding of human systems is fundamental to solution-focused thinking and that the therapist and client together create a therapeutic system. Collaborative thinking between therapist and client, both of whom bring their own expertise to a common endeavor, is the key to continuing progress.' (Lipchik, 1994: 37)

Despite his reports of success in his systematic use of SFT in three cases, which he described as 'intractable', he then in his words 'drifted from it'<sup>228</sup> but continued to see SFT as part of his current repertoire on which he could draw in the future.

The second practitioner in this area suffered a setback due to sick leave following the course. Despite this she was able to continue with her plans to try it out in her casework. Support from her team leader<sup>229</sup> appeared to have made a critical difference: 'I was waiting to use it on this family ... and the other person who was there (the team leader) was very interested in brief therapy so that was an advantage'. This initial trial was not a success<sup>230</sup> although eliciting the parents' goals did alter the worker's plans in the case (Appendix 4:11). Despite this setback, the worker continued to adopt aspects of the approach in her practice, in particular, use of scaling and what she called 'developing discrepancies' (exceptions). She also described using it in a case focused on helping a client overcome financial difficulties and this was successful. This was the only example cited where the focus of the work involved financial difficulties.

In another case of work with a teenage girl, she described the effect that she felt the focus on solutions and exceptions had:

*She herself feels stronger. I mean the situation is not good but I think she in the situation is stronger and safer ... I didn't have the luxury of doing it each time I saw her because of the nature of the case. I'd be bringing her back into care, or bringing her here, there and the other. It might only be ten minutes of our drive from one end of the city to the other<sup>231</sup> ... I think she began to believe more in herself. I think her self-esteem went up.*

This worker had maintained use of the approach. She also had a view that for particular cases, co-working was necessary because it could be exhausting doing it by yourself.

#### *Area ethos*

A feature that was evident in the account of the workers from this area was the level of respect demonstrated towards clients. When adopting SFT, workers from Area A told clients in advance that they were going to try something new and sought their agreement for the change. None of the workers from other areas operated the same practice.

Another feature was the extent to which the ethos of the approach fitted with the ethos of the area. This was made particularly explicit by the team leader:

***It sounds in ways as if you may have incorporated it more as a way of thinking then?***

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<sup>228</sup> The drift he attributed to a move into a management position.

<sup>229</sup> who did not attend this training but who was trained and interested in the approach.

<sup>230</sup> In the sense that the worker had hoped it might help her to actively work with parents towards the return home of a child cared for by neighbours.

<sup>231</sup> Echoing Stevenson's story of 'Ethel' and the positive work possible on car journeys cited in Chapter 3 to indicate that therapeutic work does not only take place in clinic settings and does not necessarily involve 'a therapy session'.

*Yes, we have tried to incorporate it as a way of thinking and also how we view families. I think that overall it feeds into our beliefs, attitudes and what have you here, in that respect for people and that people try ... they try very hard to work things out and they are not always trying to deliberately go around and sabotage their lives and other things.*

***And which do you think came first: that actual attitude or way of thinking in the team and in the area or was it the brief therapy?***

*I think the attitude was there already and I think the brief therapy fits into it very comfortably ... there is an openness to it. It's not always seen that the child or the family are the problem, it's just that interaction or that piece of behaviour maybe that can be changed.*

***So, if I asked you just to describe what the ethos is in the area?***

*I think to value people, to respect them ... to think and look preventatively. Also there is a different set of attitudes, that the families can look after themselves with help from us and that they can find their own solutions ... the ethos here is not to take children into care but to try and find family oriented solutions, whether they be friends, neighbours, cousins or relatives, to help out in times of crisis for families and to believe that at some stage down the road we can help that family get back together again. We can reunite them.*

Another feature which was evident in the accounts of the experienced workers from this area was that the *motivation level* of clients was considered a key factor in deciding whether to use the approach. One practitioner said:

*On another level then further down the road thinking about it – it seemed also that certain families would have laughed at you, wouldn't have taken it on board, wouldn't even think about talking in that direction, wouldn't be open to even talking ... Families that seemed to be against any sort of discussion around anything to do with their issues and would take no sort of responsibility for their problems. It's somebody else's problem ... So, to some extent, you need a captive audience.*

This view was shared by the team leader from the same area who said: '*you have to have a willing client. Sometimes clients are not willing or agencies are not willing*'.

#### *Fostering setting*

The two successful sustainers in fostering were both from a specialist unit and both long qualified. One was a manager and the other a practitioner. The practitioner had attended the training course because of positive reports from peers; the manager had heard nothing about SFT and only took up the training place because otherwise the place would have been 'wasted'. For both the appeal of the approach was related to their perception that it fitted with the 'empowerment' ethos of social work:

*A new way of empowering people. I remember one description vividly: these people are walking against the sea all the time, and that just literally seemed so apt. How do they keep going?, but yet they do keep going. So [SFT] is a way to build up their strength and confidence.*

*What I feel is that it is about giving people back power and making them believe in themselves...and it appeared to work (laughs) from what we could see. And as I say I was very taken with it having gone with a very cynical view – not a very interested view. And I thought it was great.*

It was also viewed as accessible and more 'user-friendly' by one respondent:

*Struck by it as a more casual approach. If you were able to use it properly, it could almost be seen as a friendly conversation – different from other therapeutic ways...a very practical approach for people. It was more manageable than a lot of other therapies – you could relate to it.*

The practitioner tried it out immediately after the course, and related this to one of the training videos which had dealt with a similar situation with a fosterparent. In both her trials she used it with teenage boys in placements which were running into difficulties and she did individual sessions with the boys alone. She achieved some success in both, although improvement was not sustained in one situation and the placement subsequently broke down. Nonetheless, she saw it as an innovation which fitted with her existing ethos and way of working in building on people's strengths and confidence (*'I think I was already trying to do that'*) and one she would like to continue using but was finding difficult to sustain as the focus of her work had changed to more recruitment and assessment work. She therefore remained at Stage 3 in the innovation-decision process.

The manager in this unit was sceptical prior to the course but came away from the training feeling that the approach had merit. This was not an unconditional acceptance however. While she could see that *'it could fit a lot into just general casework or social work in community care'* she saw a limited role for it in her own work in fostering and adoption. Like some other early adopters, this respondent gave an account which suggested that she assessed the approach and its relevance fairly quickly, reached a decision on its potential and then implemented it straight away: *'what I used was the miracle question with adopters and the scale and how they'd get to a different place ... and the positive bit.'* There was an indication that it fitted well with her own ethos and way of working. Referring to the emphasis on *'the positive bit'*, she added:

*Well, I would have been into that anyway really because when you're working in adoption, people are so distressed and so upset that you do focus a lot on the power, because they do seem so powerless ... so those bits would have appealed to me and would already have been part of my practice.*

With a high level of confidence, she took the aspects that she saw of use and 're-invented' them (Rogers, 1995) to suit her work: *'I would use it in terms of fertility with most of the people that I would have assessed around that time.'* She also described how she had acted as a *'product champion'* and spread the news of the innovation and its potential use:

*And I think the team would use it too now ... I gave a presentation [to the team] and we looked at it ... as far as I know, people in the team, or some of them use parts of it – those pieces – in their assessments now ... I would talk to any new workers [about SFT] ... when I do group supervision or anything like that, we would use that [SFT] as part of it.*

For this manager, there was a sense that her enthusiasm for the approach was well established and perhaps would be 'stored' for further use and examination in the future:

*I think just the whole focus of it about giving people power is just great. It really is ... I really went very cynical because I'm not into quick fixes. I don't believe in them. I only believe in the slow painful route (laughs), but I really was very impressed.*

### *Therapeutic settings*

5 respondents from therapeutic settings sustained use of the approach after initial experimentation. Although two remained at Stage 3 with some difficulties in implementation, the other three were adopters by the time of interview. Four of the five had over eight years experience each; only one was recently qualified. They were in different settings: three in separate child and family psychiatry services; one in a health board family centre and one in a counselling service. They were all practitioners<sup>232</sup>.

One of the five attended the full four days of the training; the other four attended for two days. All had chosen to attend. Three practitioners mentioned the appeal of SFT as brief and focused. One recently qualified worker had already become interested in the approach while on a student placement. Another worker attended primarily because of the positive reports of peers.

The aspects of the SFT approach of particular appeal were the focus on positives and the accessibility of the approach:

*I came away with these basic concepts and I knew I can actually go ahead straight away with the next person that I would actually see and actually use the concepts;*

*I suppose the fact that there were specific techniques struck me ... the miracle question, the scaling, and the whole thing was so practical.*

Two practitioners spoke of how it fitted with their existing ethos and preferred methods. One spoke of having done NLP<sup>233</sup> training which ‘much more concentrates on a positive frame of reference’ and with which he was very impressed. For him, this meant that ‘*I came to that Brief Therapy course with that positive frame of mind to that approach but without any real techniques for applying it*’. For him SFT provided specific techniques whereas before the training he would have ‘*already used elements of it in a very disorganised type of way, trying to focus on positives and resources and strengths ... saw [SFT] as a way of helping me to do that.*’

Another said how the emphasis on the strength of clients in their contexts: ‘*fits in with my attachment to systemic thinking – say, for example, the Milan<sup>234</sup> method where they may similarly talk about positive connotation and looking for clients strengths*’.

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<sup>232</sup> Two of the five had originally attended the training as members of the Area 8 social work team, and had then moved jobs.

<sup>233</sup> NLP is Neuro-Linguistic Programming, an approach to therapy which focuses on coaching people and is derived from the work of Bandler & Grinder (1976). It has been described as ‘the art and science of excellence, derived from studying how top people in different fields obtain their outstanding results. These communication skills can be learned by anyone to improve their effectiveness, both personally and professionally’ (O’Connor & Seymour, 1990).

<sup>234</sup> The Milan approach refers to the Milan school of family therapy, developed in the 1980’s by Selvini Palazzoli and colleagues (Selvini-Palazzoli et al, 1978; 1980).



Both started using the approach immediately after the course and reported that they had incorporated SFT interventions into their practice.

*I would have built them into my work where they wouldn't have been before;*

*It certainly is present for me a lot of the time. I'd be conscious of it in any interview I'm doing.*

Neither adopted the whole model but took the concepts and techniques that they felt fitted, and incorporated them. Both of them also had already made judgements on where it would not be appropriate to use it and again it appears that reflection on the approach after training was important in that regard:

*Probably in thinking about it afterwards ... cases with a lot of emotion involved, post-traumatic, bereavement ... [I] would feel reluctance, particularly doubtful in starting off with people using this approach. (my emphasis)*

*I'd be mainly thinking of using it in situations that are family based or that are counselling-type situations that clients might present themselves with, as opposed to situations where somebody might come, say, with some educational connection that they want information about something.*

Pattern of experimentation: All 5 started using it immediately after the course, and did so single-handedly, as opposed to working in pairs or being actively directed or supported in its use. In all cases they selected aspects of the approach rather than following a set model.

Three indicated that they were using it both with children and parents together and also with adult and teenage clients individually. For all, adoption of SFT had clear advantages, and for several the main advantage was the way in which they 'heard' clients in a new way. One spoke of using it the day after the course ended with a young person in care in crisis<sup>235</sup>:

*I asked her the miracle question, got such a clear picture where she would like to be, how she would like things to be different ... It completely shifted the focus of my work. I was trying to keep together the placement. She created a crisis and got herself out of the placement. The ideal didn't happen, but something that suited her a lot better happened.*

Another used it with an adult client with family problems and similarly was struck by how different her perceptions were from those of her client (Appendix 4: 12). This appears to have been a significant learning experience for this practitioner and one which continued to influence her practice: 'I tend to look at people in a different way ... Now is there something here that I'm not picking up or that I'm not allowing the person to say, and I throw that in now'. Unlike the other four sustainers from therapeutic settings, this worker from a health board family centre (located in one of the areas of non-use) still appeared a little unsure about her application and so she remained at Stage 3 with continuing difficulties around implementation. Her account indicated that she was

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<sup>235</sup> This practitioner was in community care when this trial took place.

unsupported in her work and lacked feedback, other than her own observations, on the perceived impact of adopting the innovation:

*I don't know anybody else who does it ... I don't even feel that I'm doing it now in a proper manner. It's a bit fragmented ... I'd like a refresher course and I'd like to be able to talk about the times that we used it and what happened and maybe to use case histories: 'would that have been different or what happened there?'*

A newly-qualified worker, originally in community care but now in a child psychiatry setting left the course with particular aspects of the approach in mind and continued to use only those:

*I took a few of the basic concepts like using the miracle question, like not focusing on the problems, like scaling about relationships. And they are really the only three concepts that I think I have kind of internalised in myself.*

For this practitioner, a perceived benefit of the approach was the effect it had on her as a worker. She described how, in working with one particular mother with a long history of abuse in her own childhood and current addiction problems, she as the worker felt less overwhelmed by the enormity of the difficulties through focusing on some of the positives:

*I think stepping back from that and looking at ... OK, what are the things that are good? What are the things that are good about your relationship with the children? I think it was less stressful on me ... that I did not have to take the responsibility for what was actually going wrong.*

She thought it had also altered the client's perceptions and ability to cope:

*I think it was easier for her because we didn't focus on all the bad things. I think that was the word she used to use [for things] that were happening and all the awful things that had happened her in the past weren't focused on as much, and at the end of it was: right, well these are the things that are going OK which might have been only one small thing. Like that the children had gone to school every day of that week, and she was getting on better with the eldest girl ... and helping her to look at that so that she was more positive about it.*

This worker's account also covered her decision *not* to use SFT while working with Travellers because of the extent of deprivation encountered by this group, and the consequent focus by the worker on practical needs:

*I was working with Travellers. And a Traveller's life is full of – it's very hard to say what is going right when someone does not have a tap, a running [water] tap, a hard ground [for a caravan], a house to live in or a roof over their head. It's very hard to focus on what's actually good for someone [in those circumstances].*

The *element of hope* for both workers and clients re-emerged in the accounts of these workers:

*In terms of work with social workers, it [SFT] helps to focus on taking the crisis and the chronic-ness almost out of our cases ... it helps because I think then if you're positive about what you're doing, then you can instil that in the person who's coming to you, that's dragging you down and then you kinda get stuck and then they get stuck ... I think it lifts me and I can see it lifting people when they say: 'yeah, yeah we did that, you know.' That's a good thing ... it helps focus on a task ... it helps create ... a light at the end of the tunnel, that you can actually see a light, that you actually know that people are moving forwards rather than being stuck in the tunnel and you can see only darkness.*

*It's new and it's refreshing to clients because you are asking them to look at things that are working well within the context where they mightn't have seen anything working well ... It conveys a sense of hopefulness ... and I think that's good. One of the things about clients, in my experience ... when they come in here, if they are feeling pretty awful about things, they like to go out the door feeling hopeful.*

There were indications also from this subgroup that job and location changes interrupted adoption of the innovation and that slippage had occurred for this reason. Two of this group moved location after the course; one also moved to another part of the country and the other had also been in another locum position in the intervening period. Both spoke of how their energies were caught up in learning about their new role in multidisciplinary settings and there were also indications that they had to an extent tested the water in their new settings before making explicit their interest in or use of SFT. One had plans to do so:

*I myself am doing an in-service day in the clinic and I plan to use the brief solution focused therapy which means that I know between now and March that I will ... be concentrating on it and brushing up on it and very much selling it. That's the way I look at it – to sell it in the service, in the clinic I work in.*

The other was experiencing some tension with her own eclecticism '*There's no one theory for everything ... over the years you build up a number of different ways of working. I'm always looking for new ideas*'. This combined with the seemingly medically-oriented service she had moved to where: 'there would be pressure here to have a diagnosis' and she remained at Stage 3 of still experimenting.

The difficulties for single-handed adopters in sustaining the energy and interest in a particular innovation was again evident with this group, most of whom would have welcomed support groups or further training inputs in SFT.

The concept of inter-professional competitiveness and challenges are also evident in these accounts. Unlike those in single profession settings such as community care, workers in these settings referred to the importance of their professional status vis-à-vis doctors, psychologists and nurses.

### **The 15 'returnees': their reported experiences between the training event and time of interview**

As already indicated in Chapter Six, there were 15 respondents who had attended training in the SFT approach prior to the Oct. 1995 event. They were from a range of settings as indicated in the following table.

Table 17: The 15 ‘returnees’ by agency setting

Child Protection	Child/Adult Psychiatry	Fostering/ Adoption	Medical	Vol. agency
4	4	4	1	2

(13 of the 15 were still in the same posts and two had moved<sup>236</sup>)

They were also at different stages of the innovation-decision process at the time of attending the course:

- 6 were at Stage 2 (Persuasion/Decision) and had essentially not yet made up their minds about the innovation. They had returned to the second SFT course for additional knowledge.
- 9 were at Stage 4 as they viewed themselves as confirmed adopters who were returning for skills development, ‘refresher’ training and/or to consider its application in additional situations (such as one respondent’s cited ‘additional need’ of looking at its implementation with involuntary clients).

While it was difficult for this group to distinguish their usage of, and their thinking about, the approach before and after the Oct. 1995 short course, an attempt will be made here to address the question: did the second bout of training appear to have an impact on them in relation to their thinking about or doing SFT; and if so, how?

### *Stage 2 respondents*

For 6 of the 15 who were not persuaded about the innovation, the 1995 SFT course provided them with an opportunity to observe SFT in action again (through video clips, role-plays and exercises contained in the training) and to discuss, practise and reflect on the approach and its potential use away from the pressures of their working environments. It also gave them an opportunity to separate out their ‘know about’ and ‘know how to’ knowledge and skills (Fook *et al.*, 2000).

Their accounts suggest that the second course gave them firstly a chance to compare the innovation and its potential with their existing methods and mental maps and secondly for some to consider further the conditions that they felt needed to be in place in order for them to use it<sup>237</sup>.

*One manager*<sup>238</sup> from a child psychiatry setting in a service with chronic waiting lists, described how she had been attracted to the approach because of its brief label and also because she was

<sup>236</sup> One practitioner had moved into a management position in the same service in the intervening period and another one had moved from an area-based child protection post to an adoption and fostering post in the specialist unit.

<sup>237</sup> They were therefore still considering its *relative advantage; compatibility and complexity* (Rogers, 1995) and were taking their time about it, indicating that in Rogers model they would be considered ‘potential later adopters’.

looking for an ‘extra tool’ to use in ‘*situations that were either stuck – where there had been years of contact and not an awful lot of change – or paralysis – that the family and the team dealing with them were stuck*’. She had used the first course to ‘hear about’ the innovation, and she returned to the second in order to ‘*apply what he (the trainer) had described in the first module*’. Her opportunity to reflect further on the approach during the second SFT course led her to wonder about its compatibility with her established way of working and of perceiving problems. There was a clear sense in which she disagreed with the fundamental premise of the approach:

*I suppose one does wonder from time to time about the trauma suffered and the feeling states that go with it, and if there is a shortcoming to it, I would see it as a method of work that doesn’t address the trauma suffered and doesn’t give people a chance to rework the trauma and I think that is quite a drawback ... And the nature of the work that we do here – that would be a very large focus.<sup>239240</sup>*

The second course appeared to confirm for her that the innovation would not fit in her work, yet she did not reject it totally and did talk about sometimes drawing on two specific questions in her work. Her lack of enthusiasm for or limited engagement with the ideas suggest that she remained at Stage 2 (unpersuaded)<sup>241</sup>.

*The other manager<sup>242</sup> in this group* was from a voluntary agency and had attended the previous training while a practitioner in community care. Although she had tried the SFT approach with success in that setting, she had found it difficult to sustain its implementation<sup>243</sup>. Her decision to attend the 1995 course was triggered by her change of location and her perception that the innovation might be of particular use in work with sensory deprived clients of the agency, and thus suggested a tendency to ‘store up’ potential approaches and to return to them if conditions became more favourable.

She described how she ‘*found it [SFT] easier to use after the second [course] as opposed to the first but that may be to do with being in a different work setting where it is easier to use*’, suggesting that the change of client group was key for her. At the end of the training, she ‘*felt committed to using it and certainly wanted to use it in my work*’ but she ‘*needed to find a way to be*

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<sup>238</sup> This manager also engaged in some direct practice.

<sup>239</sup> The notion that work with ‘trauma-organised’ families can effectively draw on SFT has been suggested by leading family therapist, Bentovim (1992) as well as one of the proponents of SFT, Dolan (1991; 2001).

<sup>240</sup> Yet, interestingly, a colleague of hers from the same agency did not mention ‘trauma-work’ at all.

<sup>241</sup> The lack of any real trial in the approach suggests that she fitted into one of the later categories of potential adopters, and her concern for system norms (in that she was one of the few respondents who asked whether there was good feedback about the innovation generally) suggests that she wanted to be seen as still open to it but her general account suggests that the two bouts of training did not really lead to any changes of practice at all or that the innovation was viewed as offering her alternatives to existing practices.

<sup>242</sup> This manager also engaged in direct practice.

<sup>243</sup> This respondent had been in one of the areas of the health board which lacked support for the innovation and which was particularly crisis-focused, as described by other respondents.

able to do that ... maybe to make contact with other people to do that and to make it easier'. For her, support was required for transfer to take place because 'when you are in the training you are saying: yes, yes that would be great ... you are figuring out various clients and where it would fit with each client and how you are going to adapt it'.

At the end of the 1995 course, she was still struggling with how to implement the innovation. Implementation called for a measure of 'reinvention'<sup>244</sup> given the actual forms of communication required for this client group. Reinvention is often desirable because 'Flexibility in the process of adopting an innovation may reduce mistakes and encourage customisation of the innovation to fit it more appropriately to local situations or changing conditions' (Rogers, 1995: 177). Fook *et al.* (2000) refer to the process of re-invention as context-specific translation.

This worker explained how she had adapted it to work with sensory deprived clients and how she was using it is an example of reinvention (Appendix 4:13). Once she made that adaptation:

*It actually translated very well once I made the move on [re-invention] and made it my own ... It is actually quite visual ... and [the client group] do actually like to be in the 'here and now' and not have to go back through a long history so I think it is actually very applicable.*

In this case, it was a new co-worker who made the difference and enabled her by the time of interview to have moved to Stage 4, rather than the course alone:

*... a member of my team here would have attended brief solution focused training in America so herself and myself would have worked out on various clients how to approach it. She wouldn't have used it much herself either so we were a support to each other in using it.*

This worker felt that exposure to the approach had also improved her practice as she felt more positive and optimistic about her work:

*[It] affected my mindset, definitely ... on a few levels ... I feel different in that I try not to focus on seeing clients as a problem ... I feel that it has invigorated my work again. I find it far easier to be positive in my work, and it does certainly change how you view people and how you approach people.*

The other four practitioners who had initially been at Stage 2 were in health board social work based in areas E, B, C and J<sup>245</sup>. Three were in fostering posts and one in a generic post. All had attended the previous Iveson course in March 1994.

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<sup>244</sup> Reinvention is defined as 'the degree to which an innovation is changed or modified by a user in the process of its adoption and implementation' (Rogers, 1995: 174).

<sup>245</sup> One of these practitioners had been in Area J for most of the intervening period but had transferred to the specialist fostering and adoption unit just prior to interview.

One had the active support of a colleague who was also using SFT for some months following the 1995 Dublin course; another was in an area where there was a climate of acceptance for SFT rather than active support offered. The other two practitioners came from areas where there was no climate of support or interest in SFT.

All four returned to the 1995 SFT course, because, although they were attracted to the innovation, they were still having difficulty in seeing how they could use it in their practice. The appeal of the approach was that it was positive, that it enhanced clients' own abilities, that it included techniques to operationalise the philosophy of valuing clients as people, and that it offered hope both to clients and to workers.

Three had attempted a trial and one of the fostering workers had used it with success more than once, but all four accounts suggested that they were still struggling with it on one (or more) of three levels:

- a) did they understand it correctly (complexity)?
- b) Would it fit their work or how could they fit it in their work (compatibility/relative advantage)?
- c) Was it possible to use it without support (trialability/observability)?

Two of the four indicated that they had difficulty '*getting their head around it*', or '*getting the hang of it*'. They appeared to lack confidence in their ability to use it and even the practitioner who had paired with a colleague for a period (and whose colleague went on to become a confirmed adopter) remained unable to implement it in her own practice:

*I was trying to think how I could use them [the ideas and techniques] in [fostering] assessments but ... time doesn't allow, work doesn't allow ... There was interest and enthusiasm. It's just the fact that everybody was under so much pressure to get what would be considered the real work out of the way ... in my job I was under constant pressure to get families.*

Another of the fostering workers described her ambivalence and how the lack of support or the opportunity to even talk out some of her reservations reinforced this:

*While on the one hand there was a level of scepticism, on another level there was a sense that it could work ... I think it was to do with the attitude of mind, really ... I think I needed a change of attitude myself and I think that is hard to sustain without talking about it and being with colleagues who would think the same.*

The child protection worker similarly still had concerns about using the approach, following an initial trial which had not been successful. Like one of her colleagues from the same area office (who rejected from the outset and did not attempt to use it at all) she perceived a significant difference between the examples used by Iveson during the training and her own client group. This

was related to the issue of whether contact was voluntary or imposed, whether clients were coming with a problem that they wanted to work on, and whether there was a fit or lack of congruence between the worker's goals and the client's goals:

*When I think back on it [the course] I remember being aware that the people that were coming, at least most of the illustrations ... were very much people that were acknowledging they had a problem and they need help and that makes a big difference to some of the clients that we would have here.*

However, this doubt also relates to rather a pessimistic view of the relationships possible between workers and clients and the impact of the agency mandate on these dynamics. For example, there was conflict for this worker between how she felt social workers *should* work with clients and the restrictions imposed by the child protection mandate. She indicated that she was dubious of the relative advantage and compatibility of the innovation:

*It is just difficult in this line of work not to be daunted sometimes about the kind of anxious aspect of it, the kind of worries about child protection for example.*

Her assessment was that she was still having difficulties in implementation although she felt that she was drawing on aspects of the approach (specifically scaling questions).

The issue of whether courses in new approaches can also have negative or undermining effects on practitioners who fail to transfer the learning to their practice is raised by one respondent:

*I like the idea of it, I like the attitude and the view of people in it and I suppose it sometimes makes me feel inadequate that I can't do it as I would like to.*

There was no indication that the second training course moved these respondents on in the innovation –decision process, and, by the time of interview they all remained insufficiently persuaded about SFT and of its potential benefits, to sustain experimentation<sup>246</sup> without additional supports. They all therefore appeared to be still at Stage 2 at the time of interview but were potentially late adopters<sup>247</sup>.

There were indications that all these respondents (although experienced practitioners) remained heavily dependent on external support and validation:

*The one thing that I recall from the second experience [of training] that it would be very useful to work in pairs, or the other thing that occurred to me since would be that if one's supervisor was involved in it as well, that maybe could help. This is one of the things that I think is probably quite crucial.*

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<sup>246</sup> Although two described how exposure to the approach had reminded them to value their clients as people and to focus on positives where possible.

<sup>247</sup> Unlike some of the other respondents who did go on after one bout of training to adopting it, these practitioners were in contrast hesitant, and part of their hesitation is related to faults in the system which was preventing them from implementing the innovation (Smale, 1998).



While the three fostering workers found it particularly difficult to translate it into their work, there were some indications that they would wish to revisit it if they moved to another setting or role, again raising the issue of whether practitioners store potential practice innovations for future consideration in different circumstances.

*The remaining nine returnees had all been at Stage 4 (confirmed adoption) at the time of attending the training and, as outlined in Chapter Six, had attended the 1995 course as a refresher, to develop their skills and to consider its potential in different cases. Their accounts suggest that in the main the second course did not alter significantly their previous use of the innovation but it did affirm their decision to adopt SFT.*

Two of the three most enthusiastic adopters had found that movement into mixed managerial/practitioner roles had lessened their opportunities to use it but they continued to see themselves as committed adopters. The pair of practitioners from Area A indicated that they continued to use it both together and separately in their work. They perceived themselves as getting results from it as well as identifying the benefits for themselves as workers (that it helped them remain more hopeful and focused on changes that have been or could be achieved).

One worker, who had a particular interest in seeing if he could use SFT more with involuntary clients, remained cautious about its applicability in child protection assessments and there was an ethical dimension to his concerns:

*... where there is an emphasis on assessing a problem ... It's often quite difficult then to be going in and looking for positives when in your mind, you're saying this is a problem that you are facing into ... You're wondering by taking it [SFT] out, by drawing on the positive points, are you actually just playing a game or are you really finding strengths in the client? ... In terms of child protection issues...the responsibility would be to actually assess the extent of risk ... while the actual approach would be trying to pull out the positives. There's a real contradiction there and a tension really.*

While this practitioner and his colleague had used SFT in one particular high risk child protection case and had published on its use, he was now more convinced of the need for management support for its use in such cases: *'it's where you need a lot of support ... a matter of support to hold the line'*.

The combination of the initial training, experimentation and adoption of SFT, followed by the second short course and the chance to reflect further on it, had in this case led to a refinement of this practitioner's position and the establishment of some principles on the conditions that needed to be in place to justify its use in high risk cases.

That committed adopters found the second course useful in refining their positions about the innovation and developing general principles about where it would work best was supported by other accounts.

The practitioner from a medical setting who saw herself as an adopter but who saw only a limited role for it in her work was not persuaded by the second course to alter this view: *'I think the same thing – what I would have taken away from it was that this [SFT] was a specific tool I could use and that I had been using'*. She had used the 1995 course to consider whether she should use it more widely and decided on reflection that she should not. She had identified clearly the situations in which she would use SFT and those where she would not. In cases where people were coming for reassurance or for information and practical help she would not use it. In cases where clients were receiving a chronic or life-threatening diagnosis, she would be more inclined to allow them to ventilate their feelings first. Only in situations where that process became stuck would she consider using SFT, as she feared that premature use might otherwise block a normally healthy process of adjustment. She had found SFT particularly useful in working with clients who were depressed and/or isolated, and gave an example of using it with a bereaved client (Appendix 4:17). Her description of how she decided to use it in practice is particularly illuminating:

*One of the things that I'd be looking for is whether the process is going to work normally or not and whether the person is stuck and going around in circles. When I sense somebody is going around in circles, I use it then. When I sense that I'm going around in circles, I'd use it. When I feel that the process is stuck and needing a bit of a kick start, or when the problem seems to be going on and on and on and I don't think that my straight forward, usual counselling is going to achieve anything, then I would think of using it ...*

*My own tendency is that I like to get a full flavour of situations and I just have the feeling that I wouldn't get that if I were to begin straight into solution [SFT]. I just need to have a chat with clients, to get to know their whole situation. They are often full of grief and they can need a session or two to get that out of their system. (Medical social worker)*

One of the practitioner/managers from a voluntary setting, similarly described how he saw SFT as a method complementary to the existing main framework used in that service, crisis intervention, but that on another level his exposure to SFT had actually altered his whole approach:

*My approach to the work changed ... for me the techniques that have been useful have been particularly the scaling questions and I think they fit very well with crisis intervention ... I compare it to the Grand Canyon approach – you are on one side and you want to get back to the other and you can see that the gap is so wide that you become hopeless because you don't think that you'll ever ... you know, that you'll never be able to jump from one side to the other so instead of building a bridge you just stay where you are, and I felt that techniques like scaling questions and problem-free talk and all that help break down things into definable elements which is a big part of crisis intervention.*

The three practitioners from psychiatric settings continued to develop their use of SFT in their settings. Although none of them were using it universally in all cases they saw it as the most influential approach for them. They all felt encouraged to continue with it following the 1995

course. One described how he engaged in a live role-play while on the course and the effect this had:

*I brought one of my most negative cases, to have a blast at it ... I got some sense of how best to contextualise that really – using solution focused in a way that was helpful at the time. So that was a big thing – it made me understand that better.*

There were clear indications from their accounts that they were not experiencing any major difficulties in relation to their role or in relation to the perceived needs of particular clients (Appendix D: 14 & 15).

## **PART TWO: MOVEMENT OF THE RESPONDENTS THROUGH THE INNOVATION-DECISION PROCESS**

### **Introduction**

In Chapter Eight, the 52 respondents were mapped along the innovation – decision process at the time of attending the SFT course. In Chapter Nine, their perceptions of SFT were outlined and their provisional assessments in relation to some of the characteristics of the innovation described. The positions of the respondents will now be mapped again based on their reports of experimentation with the innovation in their practice by the time of the research interviews, and a tentative assessment can be made of the movement of respondents in the 12-16 month period following the training course<sup>248</sup>.

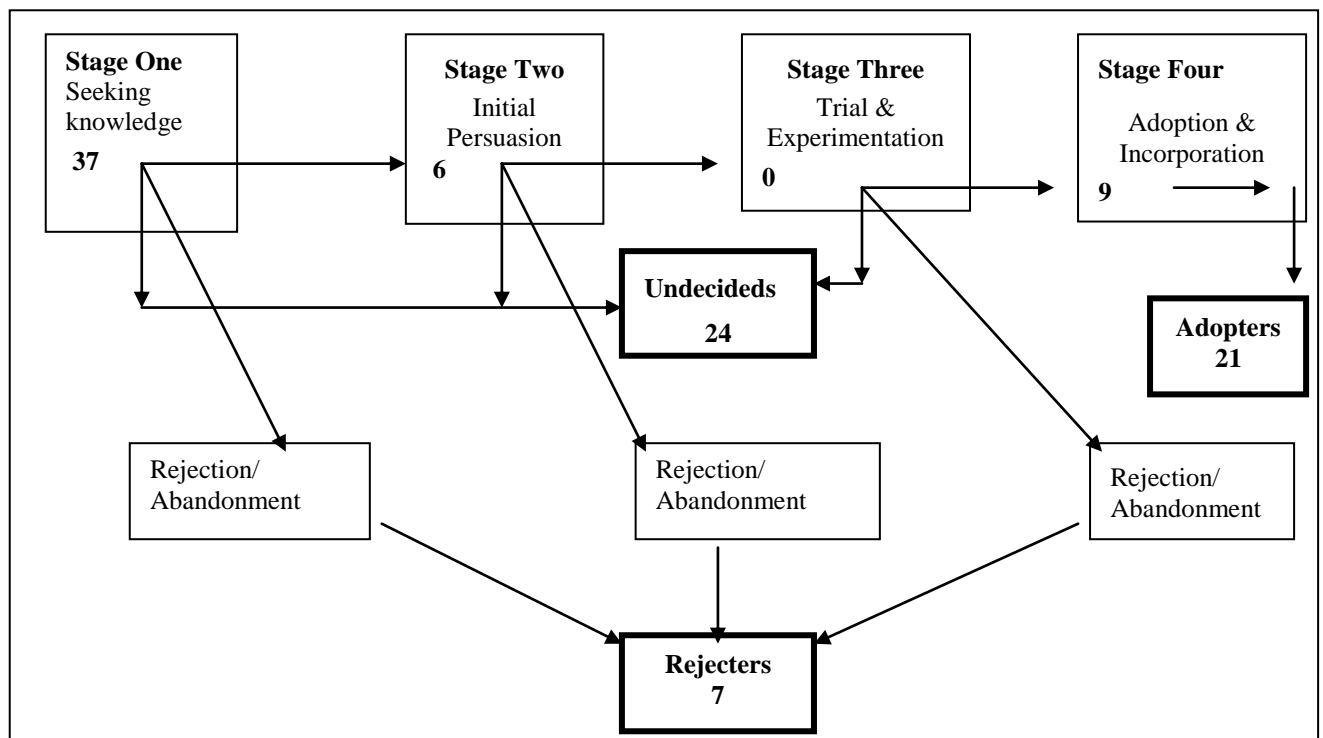
It should be noted that there had been some change in respondent's circumstances between the time of the training course and that of interview<sup>249</sup>. The profile of the respondents as analysed in the 'uptake' of the approach related to specific settings will therefore be different (Appendix E). The effect of these changes on individuals' capacity to apply the innovation or experiment with it should also be noted.

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<sup>248</sup> This is of course only an approximate measure of their positions at one particular point in time.

<sup>249</sup> In total, 4 had either changed settings or changed level: three community care practitioners from Area A had transferred – two into child and family psychiatry posts, a third into a team leader post in another part of the service. A fourth change was that the practitioner in adult psychiatry services moved into a practitioner/manager post.

Figure 7: Movement of 52 Respondents through Innovation-Decision Process (after Rogers, 1995)<sup>250</sup>



### Review of the main characteristics and factors associated with each group

The two easiest categories to map in the innovation –decision process were those of the confirmed adopters (21) and those who rejected the approach (7).

However, for the largest group of respondents, the 24 who had neither fully adopted the innovation nor rejected it, it was problematic determining what stages they were at in the innovation-decision process. The effort was finally abandoned and the decision made to allocate all these respondents into one group: those who were still *undecided* about the innovation at the time of interview.

<sup>250</sup> The numbers represented at each of the Stages is that of the number of respondents at that position at the time of the Dublin course; their movement is either to Adoption; Rejection or Undecided.

### *The early rejecters*

Table 18: The rejecters

<b>Setting</b>	<b>Numbers</b>
Fostering	2
Child protection	2
Medical	3
<b>Total</b>	<b>7</b>

- Three of the 7 had attended the SFT course either because it was a training opportunity or because they had been sent by managers.
- One of the 7 had attended for the first day only due to work commitments.
- One described how she had attended the course both because she had heard about the innovation from ‘near-peers’ and because she saw the training as an opportunity for some ‘time-out’ to reflect on her work:

*I suppose on one level there is the sense you end up just in that response mode all the time to every crisis that arises and that maybe taking time to sit down and think about what you are doing ... it seemed like a good opportunity to do that. (Child Protection social worker)*

- The ‘early rejecters’ appear to have made their decisions quickly that SFT was not an innovation of use to them and so it was dismissed. Their lack of recall of the Dublin course and of the SFT approach was striking. One respondent suggested that the innovation had been introduced into her workplace by a manager who had arranged a training seminar she had missed; another had heard about the course (and the innovation) through a mass media channel of communication (an advertisement in a social work newsletter).
- Five of the 7 had made no effort to try out the approach and only two practitioners (both in medical settings) had experimented with it. This was on a very limited basis and their accounts indicated that experiments were carried out with less than full enthusiasm. For this group, there were indications that the philosophy and general principles of the approach were not consonant with their existing mental maps or orientations, suggesting there was insufficient *compatibility*<sup>251</sup> between SFT and their own orientation to practice and their role.

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<sup>251</sup> Compatibility: ‘the degree to which an innovation is perceived as consistent with the existing values, past experiences and needs of potential adopters’ (Rogers, 1995: 224)

## (ii) The ‘undecideds’

Table 19: Profile of the ‘undecideds’

Setting	Numbers
Child Protection	11
Fostering	7
Medical	2
Therapeutic	3
Voluntary /other	1
Total	24

- There were 24 respondents who were still considering the approach and thus were at either Stages 1, 2 or 4. They were from a range of settings as outlined above.
- For these respondents (almost half of the cohort interviewed) the innovation -decision process was incomplete. While they had enough awareness knowledge, the data suggests that they lacked sufficient ‘how-to’ and ‘principles’ knowledge<sup>252</sup>.
- Some of this group indicated that by the time of interview, they had abandoned efforts to gain more knowledge about SFT. There were however suggestions from others that while they had made the assessment that SFT did not fit in their current work, they had ‘stored it up’ as a potential approach to return to if they moved into other positions. This suggests that the diffusion process in social work practice may take place over a long time period if in fact practitioners ‘store up’ approaches or ideas that they will return to in more conducive circumstances.
- All had found SFT to be of appeal, primarily because of its positive frame, but also because of its short-term focused nature. They were unpersuaded about its benefits or relative advantage but had not yet made a definite decision about whether to reject or implement the approach.
- Two respondents moved job during the period and saw this as a major factor which interrupted their experimentation with the approach. Of note is the fact that both had originated in the area of highest usage and had managed to use it successfully while there.

Respondents cited or alluded to a combination of both external and internal factors which affected their uptake of the innovation. These included:

- a) Agency conditions

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<sup>252</sup> *How-to knowledge* (‘how does it work?’) is information necessary to use an innovation properly ‘in the case of innovations that are relatively more complex, the amount of ‘how-to’ knowledge needed for proper adoption is much greater ... when an adequate level of how-to knowledge is not obtained prior to the trial and adoption of an innovation, rejection and discontinuance are likely to result’.

*Principles-knowledge* (why does it work?) is ‘information dealing with the functionary principles underlying how the innovation works ... it is usually possible to adopt an innovation without principles-knowledge, but the dangers of misusing the new idea are greater, and discontinuance may result ... if an problem occurs in an individual’s use of an innovation, principles-knowledge may be essential in solving it.’ (Rogers, 1995: 165-6)

- b) Agency role
- c) 'Fit' with individual orientation
- d) Level of confidence
- e) Level of hope

These factors will now be considered in relation to their impact on the individuals' efforts to use the innovation.

### *Agency conditions*

For those in community care (both child protection and fostering), agency conditions were viewed as a strong deterring factor not only in implementation of SFT but to innovation generally:

*... time doesn't allow; work doesn't allow – I am not saying that management didn't allow - there was interest and enthusiasm - it's just the fact that everybody was under so much pressure to get what was considered the real work out of the way ... in my job I was under constant pressure to get families [foster care] ... it [the SFT innovation] won't grow if efforts to make it work are constantly stagnated within community care teams and that is where it has its greatest relevance. (Ex-area fostering worker, now in specialist setting)*

*It would have been relevant ... at that stage we were looking to change into the new intake system ... We were very clearly looking at doing short term pieces of work with clients, looking at the issues that they were presenting and acknowledging that we were not going to solve everything ... And I would have felt that the brief therapy would have worked well in that setting ... some of the interest has not come from me ... but at that time as well obviously the whole team was going through a process of change ... it was a huge upheaval and. [SFT] got lost in the process. (Child Protection manager)*

### ***Do you think there is anything that needs to be different in relation to conditions at work?***

*Just about everything ... everybody is so frantic– they are so busy chasing their tails with High Court cases<sup>253</sup>, life or death. Like we have 170 unallocated cases in this half of the area. They don't even get time to think of what's normal or healthy or what's preventative ... the irony of it, the Catch 22 is that nothing will ever change while we are all caught up in this chaos ... Everybody is mirroring the chaos, so there is no planning ... (Child Protection social worker)*

*I certainly wanted to fit it into my own practice. I was enthusiastic about the whole thing ... I suppose I came up against the age-old thing of finding the time to look at the new approach and maybe stepping out of the old ways of dealing with things, you know? (Child Protection social worker)*

Others mentioned *the need for support* (either in terms of small group support or managerial support) as a factor. These practitioners did not feel equipped to sustain experiment with the approach without more support and guidance. One who perceived her manager as having a different orientation felt this had affected her:

*... my manager here has a very psychoanalytic approach. I did mention once that I had been on it [SFT training] and got no response. I interpreted this as very negative.*

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<sup>253</sup> Reminiscent of Cooper's study (1999) regarding the role of the judiciary in relation to child protection work, the increasing local involvement of the High Court in individual cases and the consequent diminishment of professional social work autonomy in relation to decision-making in high profile cases is noted.

Others described situations where they had found initial experimentation encouraging but either because they 'hit a brick wall' ( in this case, when the client could not identify any exceptions and the practitioner was uncertain of what to do next) or because they were uncertain about the results (observability), in the absence of any support from their agencies they had been unable to sustain it. One medical social worker in this category did not feel that he had come to 'own it' and did not feel equipped after two days training; another, who found the philosophy of appeal, a lengthy period of illness interrupted the transfer process and she had not felt confident enough to experiment without some support in place.

#### *Agency role*

Many of the respondents in this sub-group had questions about whether it fitted in their particular setting and difficulties in translating the SFT approach demonstrated on the course back to their own practice. They were medical, fostering and child protection workers:

*I wondered all right about how I could structure it ... wondered about unpredictability about our caseloads here - quite hard to control your work in child protection work ... I don't see it as relevant in doing fostering assessments: when we are assessing we are not engaged in therapeutic endeavours but I do see it as relevant in supporting existing foster parents. (Fostering social worker)*

*I suppose I'd have to think about the general pressures that we have here which are to clear the beds. (Medical social worker)*

For the less experienced child protection workers, the safety or certainty that procedures offered as opposed to the uncertainty of trying out approaches based on psychological change-work was obvious:

*I was a but sceptical really about how I could use it in my own practice ... [Iveson] was in a much more therapeutic place where people would be coming to him willingly ... where we're often going out in crisis situations ... where children are in care ... I think often we have clients with a whole range of problems where his [Iveson's] interviews – one issue, you know, maybe – they'd be bringing in one child. I mean, we work with the whole family. Loads of different dynamics ... they'd be more long-term clients too, with a wide range of problems, ongoing problems, ongoing difficulties. They wouldn't just come in with one issue. (Child Protection social worker)*

*I had mixed feelings about it ... the actual child protection ... very much what we are into here is looking at procedures – on the ground. They are clear to a certain extent, so that is around assessments and ongoing work and that. (Child Protection social worker)*

*When you're investigating an allegation of physical or sexual abuse, I don't know where it would fit in there because you are going in, you're asking certain questions, you have to do certain things: A, B, C ... There is a set procedure, there are notifications, there is a whole procedure there for investigation. I don't know whether it would actually be appropriate for circumstances like that and given that community care is now becoming very much sort of an investigative type of job ... whether it would actually fit in there, I am not sure, or how it could fit in, I'm not sure. (Child Protection social worker)*

An issue raised in relation to SFT is the extent to which the underlying principles were covered on the training course in a way that had relevance for practitioners from different settings. Principles



knowledge, Rogers (1995) suggests, is critical because 'If a problem occurs in an individual's use of an innovation, principles-knowledge may be essential in solving it (p. 166). A secondary related issue is whether SFT is equally translatable into a variety of social work settings and particularly so in agencies focused on social control responsibilities, and this issue will be reviewed in a later chapter.

#### *Fit with existing orientation*

Many but not all, specifically mentioned the extent to which SFT did not fit with their existing orientation, describing how it needed a change of attitude or a shift in thinking. They had been unable to make the shift in thinking that was necessary to adopt SFT. For some, the approach had appeal on a philosophical level, in that they felt it was the way they *should* be working; however because of the anxiety engendered in the type of work they were doing<sup>254</sup> or because they felt that they were pressurised to carry out a particular function only (such as concentrating on assessing foster carers or assessing allegations of suspected child abuse), they took what I have termed a *functionalist or reactive-functionalist position* which deterred them from experimentation with the innovation.

Others indicated that they were rooted in 'old ways', primarily focused on psychodynamic or causal explanations of behaviour and that the orientation of the approach was a major change for them. For these workers (as for others who both rejected and adopted the innovation), SFT challenged how they thought about their work but it did not mean that they adopted the innovation.

The training was, for one

*... quite strange in the first day or two – I felt disconcerted, a bit puzzled at the turnaround in thinking that you have to go through to get tuned into it. You have to break away from the old habits, particularly from the kind of training I had which would be very much looking at somebody's history, and looking at the present in relation to the past and I felt fascinated by the way in which Chris could, in his role play, the way he would approach a client knowing nothing about them, and concentrating on the here and now and I suppose it's like, with the behaviour therapy approach, hardest to get away from history. (Fostering social worker)*

*I thought: this is different ... I think it does need some kind of shift in my thinking to what I had been trained to look at, and I suppose changing the focus of being all things to all men ... and I thought: this is refreshing ... [it] is really where the client is at that you are addressing, where the client perceives there is a difficulty, and where you want to address that. it may not be what you agree ... it may be that you say that this is only part of it and unless we do x, y and z, this is not going to change and I think that's where the shift is ... all we are doing [now] is going in and out and we don't feel we are doing very much more than monitoring a situation and we talk about monitoring and support but really how helpful that is to a family, I would question. (Child Protection manager)*

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<sup>254</sup> See Chapter Two for a discussion of the levels of anxiety generated in child protection work.

For another respondent, while it was different from what she had been trained in, SFT was of appeal because it offered something different but this was not in itself enough for her to move to implementation.

#### *Level of confidence*

Most of this group lacked confidence in their ability to use it, or in the case of the two managers in the group from community care settings lacked sufficient persuasion of its benefits and of their ability to supervise it, to initiate its use in their areas. In the case of the managers, both had had the course suggested to them by their own line managers. One questioned whether, as manager, he should 'impose' a particular model:

*I would certainly be open to it ... I would think the only way it would take root in, say, in a children's home setting would be where the care workers would actually have an interest in it and take the time. And that would be a big difficulty within the health board at the moment.*

The other manager in this group described how her lack of practice in it affected her willingness to engage with it:

*... one of my difficulties is because I haven't actually put this into practice myself, I suppose I feel a bit like: God, how do I supervise somebody doing this when it is not something I can feel fully familiar with, and that I haven't any experience of, and therefore I am going very much on a theoretical base, and I felt that I wouldn't really know enough to supervise it properly. (Child Protection manager)*

These comments from managers raise an important point in relation to the diffusion of practice innovations in social work – the extent to which line managers are familiar with and competent to supervise specific aspects of direct work. Do they also need to be trained in the use of the approach? Or is it sufficient for them to know *about* an approach but leave the detailed support of experimentation with the innovation to others, perhaps peers on the team? This raises questions about how managers can best be involved with attempts to diffuse practice innovations in social work.

Most of the practitioners in this group were anxious about trying out SFT, and all cited the need for more support and back-up in their work settings, for the time and space to plan its use, and for continued skills development as the necessary factors for them to move into actual implementation.

Those for whom it fitted on a philosophical level but who were still struggling in implementing it were both fostering workers who were returning for a second bout of training; and for them the rejection appeared to arise because of the perceived *complexity* of the approach and their lack of confidence in their own ability to use it:

*I will be conscious of maybe setting out to use brief therapy ... enhancing the client and their abilities and what they have done and getting them to look at how they have succeeded in the past and looking at what they have achieved ... Now I find that sometimes*

*that demands a lot because I suppose the problem focus bit is always there with me which I find very hard to put aside really. It takes a lot of effort and you just find that you can get on a wrong track and it's hard to get back. Now I know that Chris says that you don't have to stay on that track but maybe your client is on that track and it can be difficult. I find it's like trying to jump two hoops that I'm not always able to do. (Fostering social worker)*

There were a number of respondents in this group who did not feel sufficiently equipped after the course to try SFT as a complete approach, raising again the question of what it is realistic to expect of a short course and its impact on the diffusion of a practice innovation, without follow-on support and guidance on local levels, being in place. It also raises questions about the simplicity of SFT on a surface level, compared with the experienced complexity of SFT in practice.

#### *Level of hope*

Some, but not all of these respondents, and particularly those working in crisis-driven, reactive and pressurised situations (specifically some of the health board areas) appeared demoralised. These conditions had an effect on their level of hope and optimism, which appeared to influence not only their ability and enthusiasm for experimenting with this innovation but also their general ability to remain creative in their work:

*I think I was just full of doubt about beginning something new - to use it with kids that are very cynical or smart-ass. (Child Protection social worker)*

#### **Confirmed Adopters**

Table 20: Confirmed Adopters by Setting

<b>Setting</b>	<b>Numbers</b>	<b>New</b>	<b>Returnee</b>
Child Protection	11	8	3
Child & Family Psychiatry	3	1	2
Specialist F& A Unit	2	1	1
Adult Psychiatry	1	0	1
Medical Social Work	1	0	1
Vol. Org.	2	0	2
Staff Counselling	1	1	0
<b>Total:</b>	<b>21</b>	<b>11</b>	<b>10</b>

#### *Profile*

At the time of interview, 21 of the 52 respondents saw themselves as confirmed adopters of the approach: they were committed to the approach and had found a place for it in their practice. Having found a place for it in their practice did not imply that they had adopted the whole approach as will become evident.

- 9 of this sub-group had already seen themselves as confirmed adopters at the time of the course and they were joined by 12 others, one of whom had already received training in the approach but who shifted from Stage 2 to Stage 4 in the interval between this short course and interview.

- 9 of the 21 were the only workers in their agencies who were using the approach. 7 of these were in non-Health Board community care settings.
- Of the 11 from Health Board community care settings, only 2 were ‘single sustainers’ and one of these had for part of the time the support of a colleague who subsequently moved to another location. The other 9 were in clusters: five from EHB Area A, two each from EHB Area B and H.

#### *Levels of experience*

There was a wide range of levels of experience amongst the group - those who were in specialist settings tended to be more experienced, reflecting the composition of the entire cohort. The practitioners in community care settings tended to be younger - seven of the eleven had qualified in the two years prior to the course.

#### *Autonomy in attending training*

Only one of the confirmed adopters indicated that the course had been suggested by her manager, and this was a new team leader moving to work in community care from another setting but who had an interest in the approach already<sup>255</sup>. All others in this group had chosen to attend the course.

#### *Reasons for attending*

Apart from the 9 who were returning for additional skills development and further ‘know-how’ knowledge, most of the others attended because they were attracted to the approach, had heard positive reports about it and/ or were seeking brief methods and additional tools for their work. 3 new graduates had heard about it also through placements and college teaching. Only 1 attended because it was a training opportunity<sup>256</sup>.

#### *Speed of adoption*

Unlike those who did not progress to Stage 4 by the time of Interview, these respondents appear to have made up their mind fairly quickly about the relevance of the approach to their practice and to follow up with experimentation and confirmation of adoption within a relatively short space of time following the 1995 course:

*I came away [from the training] with these basic concepts that I knew I can actually go ahead straight away with the next person that I would actually see and actually use the concepts. (Child Protection social worker)*

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<sup>255</sup> This was also the same area that ended up with a cluster of 4 committed adopters by the time of interview.

<sup>256</sup> This was the manager of a specialist unit who came because otherwise the training place would have been wasted.

*I came back and I started putting it into practice straight away. (Child Psychiatry social worker)*

#### *The pattern of adoption*

This group described a pattern of initially using the approach in a consciously formulaic way in selected cases. These tended to be cases that were ‘stuck’ (or where the worker was ‘stuck’) and where use of the innovation was a last resort. Most of these successful adopters also described how they had adopted the philosophy behind the approach so that particular principles were always at the back of their mind or they were now more conscious of them: specifically

- being more positive with clients,
- always looking for exceptions,
- being clearer about client goals or
- being reminded of the resourcefulness and strengths of clients.

The factors<sup>257</sup> which were identified as issues for those in the category of ‘undecideds’ will now be reviewed for this group.

#### *Agency conditions*

Ten of the committed adopters worked in either therapeutic or specialist settings and eleven worked in generic posts. While some of those from therapeutic or specialist settings (eg: counsellor; one child psychiatry social worker) made reference to the ‘brief’ appeal of the approach given their workloads, none gave the same sense of this being a factor which prevented them using the approach. Similarly in community care, there was not the same sense as there had been with the ‘undecideds’ that this was a factor deterring them from using it even though some were from the same areas:

*... the nature of crisis work ... sometimes you have to think on your feet ... and maybe you wouldn't be able to use different ideas or different approaches ... that wouldn't be all the time. I do have a lot of scope quite a lot of the time, or some of the time for thinking or trying out different ways. (Child Protection social worker)*

One aspect of agency conditions which was referred to as an issue was that of the multidisciplinary nature of psychiatric settings. SFT was seen by some as giving them extra status<sup>258</sup> in the eyes of other professionals:

***How did you think it was going to fit in relation to working in a multidisciplinary setting and just the attitudes of your colleagues?***

*Well, actually it is quite nice to be able to say that I have a specific kind of therapy that I am doing ... A lot of staff changes have happened here ... I may have been here a long*

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<sup>257</sup> Agency conditions; Agency role; Individual orientations; Level of confidence and Level of hope.

<sup>258</sup> Rogers notes that ‘One motivation for many individuals to adopt an innovation is the desire to seek social status’ (1995: 213).

*time but people passing through don't really know what I do. So, it's nice to be able to say I have this new thing that I'm doing (laughs). (Psychiatric setting)*

*I would be the only person really keeping hammering away at it (SFT) here. Other people might have done the training or don't feel that confident about it and I suppose personally I feel a lot of respect from people for my approach, what I do and how it works ... I gave a training on it to the Senior Registrars - they asked me to do that. And that was a sign of their respect for it, within psychiatry, that was quite an accolade really, you know. (Psychiatric setting)*

For some of these adopters, therefore the adoption of SFT resulted in social and professional prestige. For another of these respondents, however, the experience was more mixed, although it appeared to increase her determination to hold onto the method:

*I left Marino with a pile of books (laughs). And my first thought was that I was going to convert the world. And I canvassed here ... to see if there were people interested in working this way and there weren't really ... I think they were frightened of change ... well, everybody sort of looked. People, they said, that's great but I couldn't see that working ... they had a lot of negatives and I had to think hard about what it was that I was doing because there were so many negatives about the ideas when I discussed them. Like even just the simplest idea of saying – maybe we should ring up people before they come in (pre-session change). Well they were horrified here and I got lectures at length from several people about legal rights and legal obligations and liabilities to be sued ... I think people don't like change because change is hard for people. They might expect it from their clients but they are very expert-minded. (Child Psychiatry setting)*

Another aspect of agency conditions which this respondent's account raises is that of the local culture or ethos: what is acceptable to do, and what is supported as 'good practice' in specific locations. For this practitioner, her autonomy as a single-handed social worker on a multidisciplinary team meant that she was able to continue using it despite perceived disapproval from other professionals but it was a lonely position.

For others, working in community care teams where one is actively line-managed, the situation can be different. There was clear evidence from one of the managers in the area which had the highest cluster of use that there was a specific ethos in that area with which the approach fitted. This indeed has to be seen as an agency condition (a norm of the social system) which supported diffusion of the innovation. However, it was also the case that one of the confirmed adopters was working in an area where there was no perceived support and where there appeared to exist a reactive-functional way of working but she had managed to retain an ethos in her own work which fitted with the innovation which indicates a strong internal locus of control and approval. Like Reid and Barrington's (1994) non-conformists, clearly she was less dependent on the approval of others, or less interested in 'fitting in' than others who conform with the dominant culture.

The possibility that support can either sustain an innovation that individuals are finding hard to implement or can renew use where an individual lacks confidence is evidenced by the experiences of one respondent who moved setting, found she needed to reinvent SFT for her new client group

and was able to do this because she had the support of a new colleague. In this case, the agency condition that made a difference was the presence of a supportive colleague within the same agency.

### *Agency role*

Unsurprisingly, for those from therapeutic settings (child & family psychiatry, adult psychiatry, counselling) there appeared to be the easiest fit between the approach and what they perceived their role to be. They felt able to take either the whole approach or aspects of it and start using it straight away. They did not describe having any struggles about how they could implement it, but as already noted none saw it as universally applicable. One respondent spoke about her doubts about using SFT in cases of domestic violence after her experience with one case (Appendix D: 16).

That not all those from therapeutic settings adopted the approach illustrates the influence of individual orientation and attachment to existing forms of knowledge on adoption-decisions. Setting alone does not account for patterns of adoption.

For those from specialist settings (voluntary agencies, specialist fostering & adoption unit, medical) there was more of a sense of needing to think about *what* aspects to incorporate and *how*. One of the 'returnees' had attended the second training course to get new ideas about how to implement it in her new job in adoption.

The one successful adopter from a medical setting found a place for it in her work but only in particular cases and she was clear that her role encompassed other functions:

*I have usually built it in as part of other types of approaches ... traditional counselling approaches, and to be honest, what I did and what I still do to some extent is when I find myself at an impasse, when I'm not really reaching somebody, I would begin to use that, and found that extremely useful.*

One of the managers from a voluntary organisation was clear that for a lot of their clients, poverty and structural issues were the central problem, but that it was also valid for workers in this organisation to engage in psychological change-work given how demoralised and shamed clients can become:

*Most people who come ... [here] see themselves as absolute failures ... When you are able to break that down and say: 'OK, what about your ability to keep these children relatively happy in a situation which is intolerable, what do you have to say about that?' And they go: 'Yeah, I never thought about that.'*

For those in child protection settings (10 in all), the 'jump' from training to implementation was greatest, and these respondents did not differ from their colleagues in being mindful of their responsibilities. The team leader from Area A made some valid criticisms of the approach in relation to this: *'in social services you have a legal responsibility that the brief therapy doesn't*

cover', but despite this she also felt that 'In some respects there are no situations [where it is absolutely not appropriate to use it] but in other respects there are'.

In fact she, like some of the others in this group, was making a distinction between cases where there was denial that problems existed and those where clients accepted a need for, or wanted change:

*I'm thinking of a case we have at the moment, where a child has disclosed sexual abuse in the family and he has run away and won't go back and he is acting out in school. You could probably ask the teacher to implement this [SFT] or you could see him individually to do it, but there is no point in using it with the family because the family are denying that the abuse ever occurred.*

What was different about these workers was that they were thinking about ways to work *around* the child protection mandate as opposed to seeing it as overarching and all encompassing:

*Sometimes in child protection ... social workers can have their own agenda ... and it's trying to work around that and that's where I find brief therapy can be quite helpful.*

Another spoke of how it can be very difficult to hold onto a focus on the positives or exceptions when your role is to assess the extent of the problems but again it was not seen as impossible.

For others, this meant careful thinking before using it selectively in certain cases:

*I suppose what I'm conscious of is that the bottom line mandate in our work is child protection and very often it is a crisis run service. Very often we are responding to crises. What stuck in my mind is that yes from time to time perhaps as a duty worker with something new coming in, or on an existing case where you ran out of ideas ... I feel I have a greater repertoire and have been skilled up a little and have something more to offer.*

Similarly to other health board workers, this practitioner made a distinction between voluntary and involuntary clients. He would not use it in cases which were primarily investigative:

*I'm thinking of, say, cooperation with the Gardaí. I'm thinking of investigative work from the beginning where people don't want to see us at all and who won't acknowledge or don't feel that there is a problem and don't see the point of having any conversations.*

While the successful adopters from child protection settings remained enthusiastic about the approach and its principles, they generally reported more caution about its applicability, although the range of examples that they gave of usage indicated that it was being used in 'risky' situations and in assessment work as well as for example individual work with children in care:

*I certainly saw it as something that could work particularly well with children and I began applying it on cases that my team had ... we have tended to use it mostly with children. One of the other teams used it with a family – co-working with a multi-problem family ... it wasn't brief ... [it is applicable] where they are searching for a solution themselves – you are kicking an open door. But where people deny that there is a problem or where they have invested a lot in keeping the status quo - no matter how dysfunctional or bad that status quo is – then I don't think you can use it. (Child Protection manager)*



*In terms of child protection issues, risks to children ... the responsibility would be to actually assess the extent of risk ... which is a negative influence ... while the actual approach would be trying to pull out the positives. There is a real contradiction there and a tension really ... that's where you need a lot of support. It's almost a matter of support to hold the line. (Child Protection social worker)*

Those workers who described using SFT in a planned way with serious cases, where children were at risk and where the intervention was taken to avoid the reception of the child into care, did so *only where they had a high level of support* either from managers, or from peers who co-worked the case with them. Two pairs of practitioners from Areas A and H used SFT and all reported positively on that experience but this did not necessarily mean that they then incorporated it effortlessly into their practice. Unlike those confirmed adopters from specialist settings for whom this incorporation appeared trouble-free, the community care advocates continued to struggle with the 'riskiness' of using the approach when concerns were high and child protection issues were being raised. Nonetheless, the advantages of using the approach in selected cases had been confirmed by positive outcomes, and they continued with their efforts.

#### *Individual orientations*

In order to become confirmed adopters, respondents needed to be comfortable with actively drawing on specific strategies. One mentioned how this aspect appealed:

*The first thing I thought was very good was the whole notion of flexibility – that you keep moving all the time as a therapist'.*

This practitioner from a child psychiatry setting, it can be noted, was comfortable with the concept of being a therapist, whereas others in the community care arenas of child protection and fostering were less comfortable with this conceptualisation.

15 of these practitioners indicated that it fitted with their existing philosophy and was their preferred overall orientation. For some this was an existing orientation held prior to the training:

*For starters, it suited my personality.... it would have fitted in very much with the way I would work with people. And I was really pleased to have a solution focused theoretical base for what I was doing rather than a problem solving one. (Child Psychiatry social worker)*

For others, it was a preferred way of thinking about the work which they had developed from the training (although they did not always consciously draw on specific techniques or use it as a method):

*Certainly it has affected my mindset, definitely ... on a few levels. On one hand I feel different in that I try not to focus on seeing clients as a problem ... it has invigorated my work again. I find it far easier to be positive in my work ... and it does certainly change how you view people and how you approach people'.*

For another worker in community care, the approach also meant she considered the length of involvement in particular cases:

*Before I call around to a family [I ask myself] what's the purpose, and what am I doing and what do I need to look at? and to try and look at an end stage ... a case I was allocated ... went to the family and said: 'look, I'll see you for four sessions and review it then and if further work needs to be done, then we'll do it', and we closed it at that time and it might open again but you know ... that was fine ... It's the kind of case that could have kept open for six to eight months ... There is no point in keeping it open because if something does come up, you know, I would have seen them again.*

*I think I am more conscious of looking at trying to handle the whole involvement and for shorter times, than to be sort of on-going and never-ending without hope ... I don't think it would work for all families if you're kind of saying: 'well, I'm only going to see you for four sessions about this', but I think it works if you're saying: 'well, I'm going to have four sessions and then we'll review it' – so it kind of keeps the focus on. (Child Protection social worker)*

For the remaining six, the main appeal was that SFT was pragmatic and that it offered the practitioner specific tools or extra tools or extra skills:

*... there was a pragmatism there to it. You might as well adopt a more positive approach ... given what you are there trying to achieve and given the fact that a lot of clients don't come for four years or whatever. (Child Psychiatry social worker)*

*I would see it as a very useful tool ... It's always there as part of my tools and when I'm making an assessment in my head, I'm always wondering whether I should use it now.*

#### *Level of confidence*

Confirmed adopters, in the main, also appeared to be more certain and confident in their professional expertise, like the 'early adopters' who have 'more favourable attitudes towards change and a greater ability to cope with uncertainty and risk' (Smale, 1998: 108).

This was not necessarily attributable to experience levels as is evident by the numbers of recently qualified workers in this group. Confidence levels appeared to be connected with the conviction that psychological change-work was, for them, part of the social work role and that they received support for this position either from managers, or from colleagues or from an individual co-worker. There was not the same sense of agonising about its use that was evident from some of the 'undecideds'. Most, even in community care settings appeared to enjoy a level of autonomy about how they went about their work. They did not appear to be as reliant on external validation as others: in other words, they had a stronger internal locus of control (Baldwin & Ford, 1988).

This was not to say that they embraced use of the approach without caution. Several expressed fears about using the approach:

*I guess the biggest fear would be that you are overlooking something that is significant because you are asking the client to define it – and some people, even myself sometimes,*

would have doubts as to whether that's really always valid ... you know if you have a conversation between three people, everyone is going to have a different version of it, so you'd be afraid that while you are helping the client change, it may be the behaviour that isn't really the one that you'd like to change. (Voluntary Agency manager)

### *Level of Hope*<sup>259</sup>

Apart from the higher level of confidence that these respondents had, there was also some extra quality evident in the sustained users in relation to the concept of hope, both for the practitioner and for the client. It appeared that some of these respondents were more conscious of the possibilities of becoming demoralised themselves and saw a clear advantage in the innovation in its perceived role in sustaining hope:

*...the focus is on the client finding their own solutions and not getting sucked into problem – focusing ... I felt it was a better approach both for the client and particularly for the worker as well. (Voluntary Agency manager)*

*It had quite an impact ... And I suppose it gave some kind of hope that families with intractable problems could actually be turned around through ... some kind of resolution of those particular problems ... the other thing is the actual shift that can actually take place when you do actually use some of the techniques ... that really is amazing - the strength of that. And I suppose the other thing would be the techniques themselves, the way that they can actually bring those shifts around ... the very specificity in one sense, yet at the same time the magical shift they can actually bring about, you know? (Child Protection social worker)*

*The questions that are asked and the attitude ... You see the client and that there is a possible solution. You're not going in there thinking: oh, my God, it is really dreadful, I'm never going to finish ... If you actually go in with the idea that there is a possible solution, it's kind of more optimistic for the worker that way as well ... I would have got that, would have felt a lot better as a worker, because it makes you feel that there is a point to what you're doing. (Child Protection social worker)*

For another health board manager, the way in which SFT encouraged both practitioners and clients was of central importance:

***Is it how that impacts then on the worker as opposed to nearly how it impacts on the client?***

*Well, I think it's a two way thing – it's the client not getting the message of I'm doing all these negative things, but sort of saying to them: 'God, that's very good, you obviously were able to look after yourself', or 'You've done some things very well' and just focusing on that. And just to give them the encouragement to carry on. Now I'm not saying that it works for everything and I wouldn't say that it works for everything but I just think that there are situations where you can work with people in that very different way and they respond very differently to it, and are actually able to take that and see themselves in a more positive light which gives them more confidence which moves them on.*

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<sup>259</sup> 'To hope is to believe that something positive, which does not presently apply to one's life, could still materialize, and so we yearn for it. Although desire (or motivation) is an essential feature, hope is much more than this because it requires the belief in the possibility of a favourable outcome, which gives hope a cognitive aspect and distinguishes it from the concept of motivation, per se' (Lazarus, 1999: 653)

### **Level of adoption for confirmed adopters**

A distinction has already been drawn between the approach as a *philosophy of practice* (the perspectives or principles level) and as a *practice method* with specific steps and interventions (the practice level). As indicated earlier, there was evidence that the training course strove to emphasise both dimensions. The data suggests that the 21 respondents who considered themselves to be confirmed adopters varied tremendously in how they interpreted and adopted both dimensions – whether they adopted mindset and techniques or whether they only adopted parts of one or both. Three different categories were discernable:

- It was unclear from the accounts that two respondents gave whether they were continuing to use it as either a philosophy for practice and/or as a specific tool. These were both newly qualified respondents in community care settings and, although they saw themselves as committed adopters, their accounts were too vague for a further delineation of their current position to be possible.
- A further 4 respondents were deemed to be using the approach in a more selective way: they had taken aspects of the approach which they had decided fitted either in their work generally or in specific situations, and they were consciously and comfortably using it in this limited way. None of them claimed to be wholehearted adherents or purists but they all shared a belief in the importance of highlighting positives. They had developed their own criteria for where it would fit in their practice and had created adaptations including:
  - the specific use of exception - finding and coping questions in inter-country adoption assessments;
  - the incorporation of scaling and the Miracle question into initial assessments in child psychiatry; and
  - the adoption of the miracle question and scaling questions with depressed and ‘stuck’ clients in a medical social work setting.
- The remaining 15 workers had adopted both the philosophy and at least some of the specific interventions, although none saw it as being universally applicable as a fixed model: 8 of this group were in community care; 7 in specialist settings.

A study of the case examples provided by respondents, along with descriptions of the aspects of the approach most frequently used, suggests that practitioners drew on the approach in a variety of ways and to achieve various ends. Individuals developed in fairly unique ways their own criteria for use. In most cases respondents selectively used *aspects* of the approach (although two of the practitioners gave examples which indicated that as well as drawing on aspects as part of their general practice, they were on occasions also using it in a fairly structured conscious manner as a framework for promoting change on a specific problem (Appendix 4: 14 & 15). These examples of a more conscious use of it as a complete frame for change-work (using SFT as a *pure therapy* model, as it were) were exceptions rather than the rule. More commonly, practitioners used aspects

of the approach either to establish goals for the work; to ascertain the client's perspective or to encourage clients by pointing out what was already achieved and what they were doing well (In this case they may be said to be using SFT *therapeutically*).

This finding confirms earlier studies (DHSS, 1978; Secker, 1993; Harrison, 1991) that following initial experimentation with practice methods, self-defined adoption and sustained use of an approach is intensely variable. In this case, it ranged from limited use of one component of the approach<sup>260</sup> in selected situations through to adoption of the philosophy as the central framework for practice and selected use of aspects of the approach in specific cases.

It is only by eliciting data from respondents regarding the precise nature of their adoption of an approach through case examples and descriptions of the processes whereby they chose to use it or not in specific practice situations that one can make sense of these variations.

Successful experimentation and adoption of a therapeutic practice method is heavily dependent on a combination of factors, the most influential appearing to be:

- Expectations and needs of the practitioner in the workplace
- Interpretation of the approach made both on the individual subjective level and/or collectively at the local team or peer level
- Individual characteristics, such as internal or external locus of control, conformist or non-conformist tendencies, personal orientation and levels of hope
- The presence or absence of support, both culturally and practically, for experimentation and innovative practice.

### **Beyond confirmed adoption**

Beyond the question of whether respondents proceeded after the training to experiment with SFT in their own practice and consequently adopt it, lies an additional question of significance: *did attending the training and exposure to the approach itself result in an examination of existing and potential practices and if so, did this have an impact on their thinking about and doing practice?*

14 of those who were either 'early rejecters' or unsuccessful experimenters indicated ways in which the exposure to the approach had influenced them.

For some, SFT was a reminder of core elements of social works, such as the strengths which clients have; or the importance of eliciting clients' views:

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<sup>260</sup> Component can either be a specific technique or intervention process such as scaling, the Miracle question or reframing, exception-finding sequences of questions, or an attitudinal aspect (related to philosophy) such as a belief in client strengths or a maintenance of hopefulness.

*I suppose I was struck by that idea that ... for most people, unless their situation is absolutely on the floor, they are holding some things together ... and that in a sense it's looking at what you are doing there to cope ... and building on that and doing more of it. I was quite struck by that. (Child Protection social worker)*

A few continued to draw on one technique which they had plucked from the model but in a way which they felt enhanced their existing practice:

*I would still use the Miracle Question ... I find that useful as a technique in isolation ... it brings you out of the problem focus. You move to looking at what can be done and it frees people up maybe even to begin to think what the future might be like – chart their way there. (Child Protection social worker)*

One medical social worker who rejected the approach as incompatible with her own style of working also indicated that engaging in the training had an influence. Being presented with an alternative model for practice required her to reflect upon and reassess her existing practices, and some aspects of the model clearly challenged her pre-existing conceptualisation of medical social work. She thought that the approach:

*... does bring you up sharply ... we do have to rethink these people who are coming to the hospital year after year - I mean, are you actually doing any good? ... you know I think I'm starting to stop being the blotting paper all the time ... it's about clarity really, and for some it drifts on and on ... I think I took the ideas really ... time-limiting is a good approach and that is something that I've been working into my approach anyway ... I took away some of the stuff about goal-setting maybe - that you clarify what you are aiming for. (Medical social worker)*

Another worker in a medical setting also spoke of how his approach to the work changed:

*The thing that challenged me was the whole assumption ... that people cannot help themselves, that they don't have the resources ... but I would say that I'm always asking people now: how you are managing while you're well, or how you're keeping above zero? ... I think it shaped an awful lot of the questioning that I do ask nowadays ...*

***So, you think it has infiltrated your thinking?***

*Yes, oh yes I do. (Medical social worker)*

*I think it helped me in being focused on the work ... it helps me to put the focus on the person themselves, to get them to do the work too. To actually identify first of all where they are at - rather than me deciding ... The scaling ... is useful in getting a clearer picture really. And I think it's helpful for the client to get a picture for themselves, of where they are at and where they want to be, and seeing the difference and that the difference is actually far less than they think and I think that is really helpful. (Child Protection social worker)*

For others, including some who made quite definite decisions that the approach was not for them, there were indications that exposure to the approach had made them re-examine and question existing practices. In some cases, their accounts suggested that this might be a prelude to change in the longer-term.

This effect was most marked with those who were qualified a number of years and had been in their jobs for some time:

*I think the thing that struck me was the emphasis was on the client thinking about how it could be ... whereas I think in the past you would sort of just tackle the problem as if you had a magic wand. (Fostering social worker, qualified over 20 yrs.)*

Given that several of the respondents quoted had been quite critical of the approach in its totality, or who had seen no relevance for SFT in their work, it appears quite significant that continued questioning threw up this additional information and evidence of an impact on the practitioner's thinking, which may in some cases lead, or have led, to more subtle but nonetheless significant changes in practice. It signals a need for evaluation of training to consider more closely these less obvious (and often unanticipated) effects.

It also raises an intriguing question: in the case of those participants who were very wedded to their existing approaches, was rejection of the approach necessary to cope with the cognitive dissonance experienced when presented with an alternative framework? And did the rejecters end up possibly incorporating as many variations to their practice as those espoused adopters who may just have been looking for a framework to call their own? Only a more detailed examination of practices of adopters and non-adopters would indicate if it is the case that the difference between them is blurred or clear.

## **CONCLUSION**

Although 88% of the 52 respondents in this study of them had found the innovation to be of appeal, they varied tremendously in whether they tried it out or not, and if they did, whether they managed to sustain implementation of the approach or aspects of it in the intervening period between the training course and the research interviews.

Following the training course in SFT, the 'newcomer' respondents left with varied attitudes towards the practice innovation based on their provisional assessments of it but prior to actual trials of experimentation. For the 'returnees' the training course had provided them with an additional opportunity to develop skills in using the approach, to bring 'difficult cases' on which they could consult the trainer, and to reflect further on its use for them as practitioners.

The 37 newcomers were able to make an initial assessment of the relative advantage, compatibility and complexity of SFT following the training course during which they had an opportunity to hear about it, see it in action and experiment with it on a limited basis in role-plays and exercises. They still had to make a decision on whether to proceed with a trial of its use in their own practice. Over half of the 'newcomers' either did not try out the innovation at all, or abandoned it after one attempt. The data suggested that there were a range of factors which influenced their decisions whether to try it out or not.

17 tried out the approach in their practice and wished to continue using it but 6 of these became stuck at the implementation stage.

While 13 of the newcomers did not attempt to use the approach at all, only 7 were 'early rejecters'. For the remaining 6 for whom rejection of the approach did not occur, conditions in the workplace (and most notably the absence of support and guidance in relation to implementation of the approach) were cited as the primary factor for this decision. These respondents indicated that they saw the innovation to be of potential value but in different conditions.

The 7 respondents who gave the innovation a 'trial', but then abandoned it, specified doubts as to whether they were skilled or trained enough to use it, and also concerns as to whether it was appropriate to use it in certain areas of work, as the primary factors.

By the time of interview the numbers of self-declared confirmed adopters had risen from 9 to 21: the number of those who rejected the approach was 7 but the largest group comprised those who were undecided at 24. A combination of individual, local and organisational factors have been identified which appeared of influence in their decision-making process.

Regarding actual use of the approach, the most common pattern was that of taking specific strategies such as scaling, the Miracle Question, the identification of exceptions and focusing on positives and incorporating them into the repertoire of the worker. While examples were given of use of the approach as a complete model for change-work, these were exceptions rather than the rule, and were unsurprisingly most prevalent in therapeutic settings where it was most likely that clients were referred for help with specific problems. For most workers in child protection, use of the approach as a complete model for change-work was only possible with a high level of support and guidance, either in the form of a supportive and informed team leader, or by co-working in pairs.

The discovery that when analysed, responses from those who viewed themselves as 'undecideds' or rejecters, indicated that some *had* changed practices and attitudes as a result of the training course raises the question of whether there was as much difference between the different categories as the self-ascribed classification system suggests. Is it that some will claim not to be drawing on innovations to reduce cognitive dissonance or indeed because of social system norms? Concurrently do those who do claim to be adopters do so because of their search for a label or framework with which they feel comfortable and/or because of perceived pressures within their social systems?



## CHAPTER ELEVEN: DISCUSSION OF FINDINGS: COMPONENTS AND PROCESSES OF INNOVATION DIFFUSION IN SOCIAL WORK

It is not uncommon for qualitative case researchers to call for letting the case tell its own story. We cannot be sure that a case telling its own story will tell all or tell well, but the ethnographic ethos of interpretive study, seeking out emic meanings held by people within the case, is strong ... One cannot know at the outset what the issues, the perceptions, the theory will be. Case researchers enter the scene expecting, even knowing that certain events, problems, relationships will be important, yet discover that some actually are of little consequence. Case content evolves in the act of writing itself. (Stake, 1994: 240)

### INTRODUCTION

In this chapter, the theoretical propositions which have been examined and supported by the findings from this study will be integrated into a redefined conceptualisation of innovation-diffusion in social work. The different components of the Innovation-Decision process and the processes interlinking the different components will be described and analysed.

### COMPONENTS OF THE INNOVATION-DECISION (CHANGE) PROCESS

There are four central components (Figure 8) located within a particular site of activity, which in this case is the field of social work practice. These components, including the nature of the site, interact together to create the context and conditions within which change will either be successfully diffused, will falter or will be rejected or abandoned. They are:

- *The Innovation*
- *The Learner*
- *The Means of Transmission*
- *The Working Environment.*

They are linked together by a number of different processes:

The Innovation is introduced into the social system through *the marketing process*.

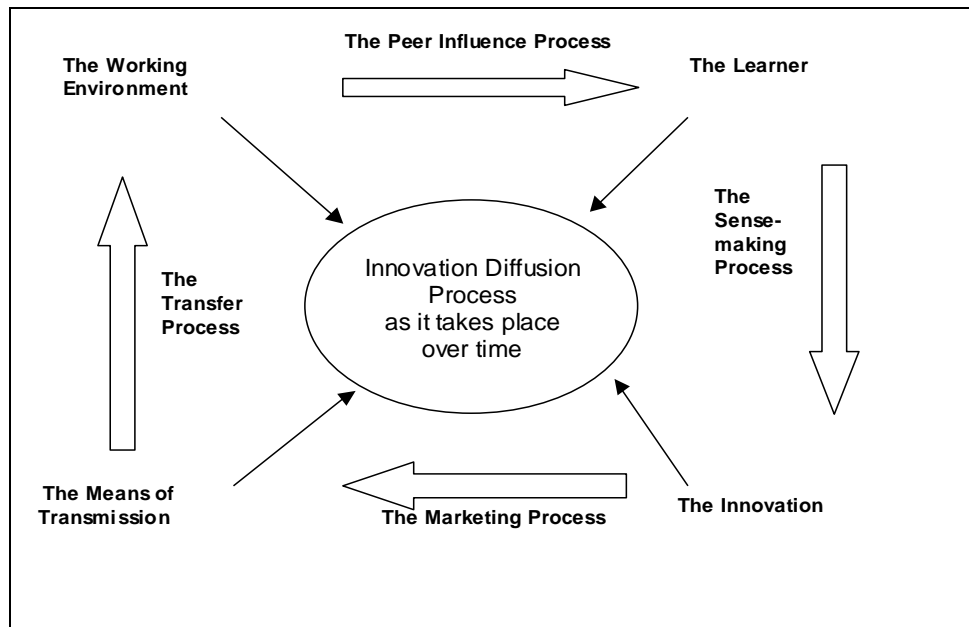
The Learner engages with the Innovation through a '*sense-making*' process related to perceived needs.

The Learners (or potential adopters) return with the innovation to their working environment through *the transfer process*.

The Learner is influenced by the working environment both through perceived conditions but also through *the peer influence process*.

For the Learner (potential adopter), the *innovation-decision* process takes place on an individual level but the *innovation-diffusion* process takes place on the social system level.

Figure 8 –The Optional Innovation- Diffusion Process in Social Work.<sup>261</sup>



Taking each of the components in turn, the findings from this study will now be considered and their implications discussed.

#### **SOCIAL WORK AS A SITE FOR INNOVATION-DIFFUSION**

##### ***Practice Innovations***

Innovations which are concerned with theories *for* practice (or practice theory) in social work and other helping professions have one particular feature which impacts significantly on the innovation-decision process, and that is the critical role of the practitioner in turning a theoretical innovation into a practice. The findings from this study confirm that uniform adoption of a practice theory is an unrealistic goal for either educators, trainers, practitioners or theorists to strive towards. The role of the practitioner as interpreter of theory is a critical component of practice.

For social workers, the introduction of theoretical innovations can only be a first step towards adoption and incorporation, regardless of the introduction process, because of the nature of practice theory and the critical role of the practitioner as translator. In innovation diffusion terminology, the practice innovation as theory is the *software*, which the practitioner as the *hardware* must connect

<sup>261</sup> The innovation-decision process takes place over time. Time is a central component of Rogers' theory and its importance is signalled here through its inclusion at the heart of the process. As the data collected in this study only covers a 12-18 month period, further studies are needed which can map the time component for social work innovations more thoroughly.

with and interpret, in order to use<sup>262</sup>. The software of a theoretical practice innovation in social work is therefore not a complete innovation in itself. It can only make sense as an innovation when it is put into practice. It can consequently be argued that practitioners can only assess theoretical innovations fully when they have their own subjective experiences of using the innovation upon which to base their judgement<sup>263</sup>. Findings from this study indicate that the practitioner's interpretation of a practice theory will be influenced by a combination of factors, including personal style and orientation, level of experience and confidence, perceived agency function and perceived social work role. The significance of the agency context and conditions (manifested in local cultures, ethos and practices) was evident throughout the findings and most striking in the presence of clusters of common perceptions, interpretations and usages of the innovation in practice.

### ***Multiple roles***

Social work consists of a range of activities and social workers are said to occupy different 'roles' (Compton & Galaway, 1994) depending on both agency and practice requirements. This assertion is borne out in this study, as practitioner after practitioner described through examples from practice a range of activities that they engaged in day after day. That they have a consequent need to draw on a range of practice frameworks or theories of helping in order to fulfil their roles was evident to all, even the most recently-qualified. An implication of the variation of activities which encompass social work is that practitioners may, depending on the diversity of their caseload, have limited opportunities to practise new approaches learnt. This hypothesis is borne out for some but not all in this study.

Practitioners in health board, medical and voluntary settings described how their work encompassed a range of activities, not all of which were perceived to be appropriate for the adoption of an SFT approach. Practitioners in psychiatry and other therapeutic settings on the other hand saw SFT as being of greater relevance although several also indicated that it was not always appropriate<sup>264</sup>. However, a distinction needs to be drawn between those who primarily found the *philosophy* to be of appeal (in which case, they were likely to report that they were 'always' now reminded of core concepts such as eliciting the client's goals and views, and remaining generally

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<sup>262</sup> Rogers (1995) defines a technology as a 'design for instrumental action that reduces the uncertainty in the cause-effect relationships involved in achieving a desired outcome' (p. 12), consisting usually of two components – a 'hardware' aspect (generally consisting of the tool that embodies the technology) and a 'software' aspect, 'consisting of the information base for the tool'. In the case of this innovation which consists of a new model for practice however, the technology consists mainly of information, both philosophical and technical, and so consists arguably only of software. The 'hardware' in the form of the practitioners 'in situ' are already in place and will act as interpreters of, as well as practitioners of this theoretical innovation.

<sup>263</sup> Although some practitioners will decide to reject on the basis of theoretical knowledge only.

<sup>264</sup> Such as the medical practitioner who preferred to allow clients to ventilate and deal with feelings at their own pace and only used SFBT if this process became 'stuck'; and the child psychiatry practitioner who used a 'trauma' based approach with most clients.

hopeful) and those who utilised the approach as a particular *method* (and who were more interested in developing the techniques to use in particular cases). Given what is known from learning theory about the need to practise new skills in order to integrate them, those who wished to use the approach more specifically as a method were constrained in particular settings from practising and developing SFT skills by the relative infrequency with which they encountered cases which they perceived as appropriate for the use of SFT.

### ***The 'invisibility' of direct practice***

Most social work encounters take place in conditions of 'invisibility' (Pithouse, 1987) - where practitioner and client (individual, couple or family) meet together without others present. The regrettable absence of client evaluation practices in Irish social work means that the voice of (and feedback from) one significant actor in the process is in the main absent. Practitioners are in this situation heavily dependent on their *own* evaluation of what happened and what was different, successful or a failure when they are experimenting with different practice approaches. Unless work is carried out in pairs or with a team, practitioners are reliant on their own ability to objectively assess a subjective experience in order to come to a conclusion about the outcomes of their interventions, or experimentation with new approaches. This is no easy task and may often result in uncertainty on the part of the practitioner about the relative efficacy of new interventions.

### ***Juggling paradigms-combining methods***

Theories of intervention at the micro level emanate from a range of philosophies and paradigms (behavioural, psychodynamic, systemic and social constructionist to name a few). Earlier studies (Curnock & Hardiker, 1979; DHSS, 1978; Harrison, 1991) suggest that whilst practitioners may ally themselves to certain methods or frameworks, it is the exception rather than the rule for practitioners to adhere exclusively to one. Different approaches<sup>265</sup> have been 'in vogue' over time in a process understood by examining the 'politics' of theory (Howe, 1992; Payne, 1997) but a question-mark over the disparity between 'claimed' adherence to an approach and 'actual' use still exists<sup>266</sup>.

Harrison (1991) queries whether adherence to one particular approach is even desirable, due to concerns that it leads to bias on the part of practitioners who stick to their preferred ideology<sup>267</sup> rather than remaining responsive to diverse practice scenarios. Curnock and Hardiker (1979) found

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<sup>265</sup> (Task-centred and psychodynamic, UK – DHSS, 1978; Community action/Unitary approach, UK – Harrison, 1991; Systems theory, Aus.– Fook *et al.*, 2000)

<sup>266</sup> And in particular studies, such as Triesolitis & Marsh (1996), findings have to be treated with caution if practitioners claims were not evaluated through examples from practice.

<sup>267</sup> Accepting that ideology is present within any organised approach to social work practice, nonetheless he wondered whether it led to biases in practice as 'These workers were often willing to treat these ideological frameworks as knowledge frameworks grounded in fact, whether they had evidence or not' (Harrison, 1991: 123).

the lack of adherence to one particular theoretical model in the assessment process entirely understandable, given the nature of social work. Furthermore they questioned whether social workers would *ever* be able to rely exclusively on theoretical knowledge suggesting that they ‘ultimately must rely on a particular blend of feelings, observations and ideas in order to come to an assessment’ (Curnock & Hardiker, 1979: 170). It is now accepted that social workers rely on knowledge from a range of sources to decide what to do ‘in action’, and typologies of knowledge (Drury-Hudson, 1999; Payne, 1997) have been developed. Fook *et al.* (2000) state this clearly:

Experienced professional practice in social work is ... characterised by the ability to juggle and apply knowledge from a multitude of sources (personal and workplace experience, contextual knowledge, formal theory and popularised applications) in complex and changing situations in which there are no clear-cut solutions. (p. 148)

The findings from this study suggest that in the post-qualifying context, exposure to new approaches through short courses, followed by perceived benefit from practice experimentation, can result in practitioners expanding their repertoire of practice theories. In the views of many of the successful experimenters and adopters, the addition of SFT to their ‘toolbox’ enhanced their abilities to be effective in their work, as they developed skills as well as ideas from frameworks. Short courses in new practice approaches that are found to be of relevance therefore offer practitioners the opportunity to add to their *store* of potential practice tools.

### ***Examining existing practices***

In the current climate of increased disillusionment with expert systems and questioning of standards of practice in a range of professions, attention has turned to the concept of continued professional development (CPD) and an examination of the various mechanisms which promote ‘life-long learning’. A core component of life-long learning is the ability to examine existing practices and to remain open to the possibility of change. Leaving aside organisationally-imposed innovations, short courses on optional innovations offer social work practitioners not only the opportunity to add to existing practice skills, but also that of engaging in an examination of their existing practices. The majority, but not all, of the participants in this study did engage in such a process<sup>268</sup>.

Exposure to a new approach can either affirm practitioners’ pre-existing orientation to practice, or alternatively challenge it. Either way, it signals that change is a possibility and offers participants a choice. Without making the assumption that change is necessarily always a good thing, these findings show that practitioners used various strategies with which to deal with disconfirming messages including those of ‘dodging and denying’ identified by Coghlan<sup>269</sup>.

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<sup>268</sup> The exceptions were a couple of practitioners who indicated that they had health or personal problems at the time.

<sup>269</sup> ‘Denying and dodging are natural reactions to the unexpected change news that change is needed. They describe more explicitly the specific reactions in the unfreezing process as experience is disconfirmed

In this study, the review process did not end with the course but continued over time. The research interviews in themselves may have been a significant mechanism in triggering a more in-depth analysis by practitioners but the accounts of respondents suggested that ideas and concepts from the short course continued to percolate for some time after the course as they proceeded to process (and also create) their own personalised learning.

Initial reactions which signalled no change were in a few cases altered to signal some change but not total change in the form of innovation-adoption. Over time, following the short course, some of those who had ‘denied or dodged’ the need for change *had* reviewed their practice further and been influenced towards changed practices even if the specific innovation itself was not adopted or drawn on. In the absence of research interviews which engage practitioners in a process of reflection, review exercises with groups of practitioners might still fulfil this function.

### ***Ideology versus ‘ideas’***

The perception sometimes exists that social workers are primarily ideologically-driven, relentlessly pursuing their own agendas regardless of the impact on their clients, and changing tack with new fashions merrily abandoning tried-and- tested models for the latest fad. Social work educators and regulators have sometimes fed into this perception<sup>270</sup>. Strong or exclusive ideological positions are viewed with suspicion: those who claim a superior ideology are thought to be driven as much by a desire for personal aggrandisement as a betterment of society<sup>271</sup> and fears have been expressed that a rigid adherence to particular ideologies may lead to an oppressive imposition of certain ‘truths’ on the subjective experiences of others. Critics of the social work enterprise, both within the profession itself (Rein & White, 1981; Trainor, 1996) and outside it (Waters, 2001<sup>272</sup>) have contributed to a perception or suspicion that social workers cannot be trusted to use theory and ideas in an appropriately discerning way. One of the consequences of this is that enthusiasm for new approaches is almost viewed with alarm even by academics and theorists (Stalker *et al.*, 1999; Howe, 1994) and fears expressed that practitioners have ‘lost’ their critical faculties.

SFT has been one of the most popular new approaches in the helping professions in the last decade and its proponents have not escaped censure (Stalker *et al.*, 1999) for what has been perceived to be

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and anxiety felt ... the initial reaction to change to be expected is that change is not necessary and that such a reaction typically shifts to an avoidance or dodging stance’ (Coghlan, 1997: 32).

<sup>270</sup> E.g.: the universal adoption of the ADP philosophy in the UK in the 1990s

<sup>271</sup> John McGahern, the Irish novelist has expressed his wariness of ideology – ‘I am afraid of all ideologies. Joyce called them those big words which make us unhappy. I think they have very little to do with life and everything to do with the struggle of power’ (Guardian newspaper, 5.01.02).

<sup>272</sup> John Waters, an advocate for fathers rights and an Irish Times journalist, wrote:

A friend of mine, a practising social worker, characterises his profession as ‘the Jesuits of man-hating’, he believes social workers are highly-motivated ideologues, trained to carry out the letter of the feminist agenda’ (Waters, 2001).

an unseemly and uncritical rush to adopt an approach which has not demonstrated superior empirical effectiveness to established methods<sup>273</sup>.

Concern about ‘the rush to be brief’ has also been voiced by one of its originators (Lipchik, 1994) after encountering disillusioned therapists who felt that SFT had ‘failed them’.

Findings from this study indicate that although interest in SFT has been sustained for over 15 years, it neither risks taking over the world of social work nor have practitioners abandoned their critical faculties in their assessment and adoption of the approach. The extent to which the practitioners in this study, even though they almost universally found the approach to be of strong appeal, were cautious and took care in their use of SFT, is very evident. Their accounts of tailoring it to particular practice scenarios demonstrated the ability to ‘transform’ theoretical knowledge of the innovation into personalised knowledge (Eraut, 1994) through its use. The care and thought with which practitioners considered adoption should reassure educators and academics that the actual transfer of practice models from short courses to practice is recognised by most practitioners as a complex matter which they engage in both critically and reflectively. A duty of care to clients was evident throughout, without any evidence emerging that practitioners embrace new ideas in a totalising ideological manner.

### ***Does experience equal expertise?***

That experience alone does not create or develop expertise in social work practice is a strong theme from recent research (Fook *et al.*, 2000). Expertise in their view is related to the ability to cope with uncertainty and think creatively in uncertain situations to which there are no clear-cut solutions (ill-defined as opposed to well-defined problems). This requires the ability to go outside common (or tried and tested) frames of cognitive understanding and action in what Harrison (1991) calls a creative heuristic search. The willingness and ability to experiment creatively with innovative methods<sup>274</sup> can be considered one avenue whereby the practitioner explores possibilities outside his or her usual frames of reference. The findings from this study support the proposition that experience alone does not lead practitioners to conduct successful creative searches of the type that are considered to be a feature of expert social work practice. The opposite may indeed be the case if experienced practitioners remain particularly wedded to their existing maps for practice and consequently more resistant to new ideas.

Some of the more experienced practitioners in this group articulated this difficulty they faced: the innovativeness of SFT was perceived as being the ‘opposite’ of their existing maps premised on

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<sup>273</sup> Although as indicated in Chapter Five of the literature review, SFT has demonstrated outcomes at least on a par with other brief therapies.

<sup>274</sup> Provided, of course, that the innovative methods are consonant with general principles of sound social work practice as perceived by the potential adopter and peer group – as the SFT model indeed was.

psychodynamic thinking, and they struggled more with trying to imagine how they might use it. For the practitioners in this study, the development of alternative cognitive maps and creative searches required more than experience alone. More important were qualities such as a willingness to take risks by experimenting, and an imaginative (or flexible) ability to consider ‘the problem’ from different angles and with different cognitive ‘frames’.

### ***Creativity and uncertainty***

The development of skills to cope with uncertainty and to think and act creatively has been identified as critical skills for contemporary social work practice (Parton & O’Byrne, 2000; Fook *et al.*, 2000). It can be asserted that those who juggle paradigms and practice methods with ease, not only have less need for a dominant framework but also have a greater ability to cope with the levels of uncertainty induced both from experimentation with innovative approaches and from a stance of remaining responsive and creative in fluid practice situations. The abilities to cope with uncertainty and to think and act creatively are, this study suggests, linked. Furthermore, they are related not only to individual-specific characteristics such as ability, curiosity and flexibility but also to agency function and work environment conditions such as social work role and levels of support or encouragement available to creative experimentation both culturally and practically.

### **THE NATURE OF THE THEORY/INNOVATION**

Consideration of a new idea does not go beyond the knowledge function if an individual does not define the information as relevant to his or her situation or if sufficient knowledge is not obtained to become adequately informed so that persuasion takes place. (Rogers, 1995: 16)

SFT, as an innovation, was perceived to have particular features which influenced both their assessments of its potential use and consequently their efforts to try it out in practice after the short course.

- The strongest consensus was in relation to its compatibility with the value base of social work and its reminder of some core principles of social work.
- The ability of practitioners to ‘unpack’ the approach and selectively apply particular interventions appeared to be a particular strength of the model.
- The question of relative advantage appeared to be influenced heavily by the agency setting.
- Perceptions of the other characteristics of complexity, observability and trialability appeared to be more heavily influenced by individual characteristics such as confidence and optimism (self-efficacy) and a strong internal locus of control.

Rogers suggests that the characteristics of innovations, as perceived and assessed by individuals, help to explain how they fare in terms of adoption rates and speeds. The first ‘test’ for the innovation is whether it is considered relevant to the potential adopter or not.



### ***Level of appeal***

SFT had a very strong initial appeal for most of the respondents. Most had some form of action plan formulated whereby they hoped to experiment with it further in the workplace following the course. There was a small number of respondents (6) who ‘dropped-out’ from the innovation-decision process at this earliest point in the process (after initial knowledge-seeking), by making a decision following the training *not* to experiment with it in practice<sup>275</sup> but the majority proceeded from the training course with some interest and motivation to experiment with it in their own practice.

### ***Innovation-specific characteristics***

Rogers (1995) suggests that innovations have particular characteristics which are of perceived importance to would-be adopters ((i) *relative advantage*,<sup>276</sup> (ii) *compatibility*,<sup>277</sup> (iii) *complexity*,<sup>278</sup> (iv) *trialability*<sup>279</sup> and (v) *observability*<sup>280</sup>). These findings suggest that all five characteristics were being weighed up before, during and after the short course, but that ‘grounded’ persuasion was only possible after practitioners made it their own by using it and approving of the perceived results obtained.

(i) *Relative advantage* – The *relative advantage* of SFT compared to other social work approaches or methods for many of the respondents was to do with the perception of it as a more positive way of working, of being hopeful and optimistic (for both practitioner and client), and containing specific strategies or interventions which practitioners could adopt and use flexibly.

It was obvious both from the accounts of the respondents in this study, and the literature review (DHSS, 1978; Harrison, 1991; Crousaz, 1981) that practitioners draw on a range of methods or aspects of methods with which to carry out their daily work and that most but particularly those who were qualified more than two years were comfortable with this position. The exceptions are those practitioners who are searching for an overarching framework or badge of identity within which to locate themselves as practitioners, and these tended to be less experienced practitioners.

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<sup>275</sup> The six respondents who decided it had no relevance for them appeared to make that decision based on interpretations of agency function, level of practitioner confidence in their skills to implement it, and satisfaction with existing methods of intervention.

The findings supports Rogers’ assertion that individuals will only expose themselves to ideas that are in accordance with their interests, needs and existing attitudes. In this case, the six respondents who perceived the innovation as not being of relevance, of not fitting with their existing attitudes and needs made no further efforts beyond the training course to seek knowledge about the innovation.

<sup>276</sup> *Relative advantage* ‘the degree to which an innovation is perceived as better than the idea it supersedes’

<sup>277</sup> *Compatibility* ‘the degree to which an innovation is perceived as being consistent with the existing values, past experiences and needs of potential adopters’

<sup>278</sup> *Complexity* ‘the degree to which an innovation is perceived as difficult to understand and use’

<sup>279</sup> *Trialability* ‘the degree to which an innovation can be experimented with on a limited basis’

<sup>280</sup> *Observability* ‘the degree to which the effects of the innovation are visible to others’ (Rogers, 1995: 16).

The findings from this study suggest that relative advantage differs according to the specific setting and context of the practitioner.

Those in therapeutic settings (as identified in Chapter 7) referred most to other approaches to practice and demonstrated an ability to critically contrast SFT to other formal theories such as NLP<sup>281</sup>, the Milan approach<sup>282</sup> and psychodynamic approaches. Practitioners who had been exposed to the Marte Meo<sup>283</sup> method drew similarities between them, but for the remainder of the respondents, the process of weighing up the potential benefit of SFT appeared to be related to the potential usefulness of selectively using specific techniques along with the positive ethos.

Rogers suggests that the sub-dimensions of relative advantage include ‘the degree of economic profitability, low initial cost, a decrease in discomfort, social prestige, a saving in time and effort and the immediacy of the reward’ (Rogers, 1995: 216).

In relation to SFT, the perceived advantages of the approach for those who did not reject it included five of these. The factor of economic profitability did not feature.

*Low initial cost* was a factor insofar as SFT was marketed as an approach that did not require expensive nor prolonged training. Participants at the short course were encouraged to consider how they might apply it in their own practice immediately. The *absence* of any structured follow-on support in the workplace (while anathema to the established wisdom on how learning works) may paradoxically have increased the appeal of this innovation to practitioners, who were not deterred from experimentation by the imposition of expectations of attendance at further meetings or courses.

*One decrease in discomfort* which was discernible from some accounts from child protection practitioners who had used it successfully was that workers themselves reported feeling less burdened by problems when using this approach. They also felt more empowered in their work because the innovation provided additional strategies and tools with which to work effectively with clients<sup>284</sup>. That the approach appealed because of its inherent hopefulness in its belief in human

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<sup>281</sup> Neuro-Linguistic Programming (NLP) is a therapeutic method, developed by Bandler & Grinder (1976).

<sup>282</sup> The Milan approach refers to the Milan school of family therapy, also known as the systemic approach, developed in the 1980s by Palazolli and colleagues (ref.)

<sup>283</sup> The Marte Meo method is a video training technique which has similarities with SFT in that it focuses on identifying and emphasising positive parenting techniques and reviewing these with parents or foster parents. It was introduced to practitioners in the EHB region a few years before the SFT approach but was a similar innovation.

<sup>284</sup> For example, one worker described how ‘fantastic’ he felt leaving a family after an effective SFT session.

resourcefulness was a strong theme from the findings. That practitioners were able to themselves recognise this feature was also obvious from the frequency with which it was specified as a particular component of its appeal.

It can also be argued that for some workers, the changing climate in the health boards with the increased emphasis on statutory child protection work had led to pessimism and a hopelessness which was alleviated by the possibility that here was an approach to practice which counteracted the social control aspect of their role. That it was not so easy to practise as it looked, and that there were no simple solutions to disagreement between clients and workers about the focus of the work, only became obvious when respondents tried it out for themselves.

*Professional (as opposed to social) prestige* was another aspect of relative advantage which appeared to be present for workers in both adult and child psychiatry settings. As one worker commented, it was nice to have this new approach you were using and to have curiosity and interest in it expressed by other colleagues. These settings were the only ones where this effect was apparent.

*A saving in time and effort* was part of the initial appeal of the approach for some of the respondents, but for others (from fostering and medical settings) there was a disapproval of this aspect. For these workers, it was seen to be *not* in clients' interests to be necessarily 'rushed through' processes of loss and adjustment.

A saving in time was not evident in the accounts of how most workers used the approach. One exception to this was a community care practitioner who described how she now always thought about how long she needed to be involved with families and her preference was becoming one where she would contract with families for a specific numbers of sessions and then review it instead of a more open-ended engagement<sup>285</sup>. In that case however, it appeared to be more the benefits of having a focused approach than saving time as such that was appreciated.

Experimentation with the approach definitely took more time and effort in most cases, and many of those who adopted it consciously in specific pieces of work spoke of how exhausting it could be to continue to focus on and search for exceptions and positives in problem-saturated scenarios. A saving in effort was identified by some in reference to use of the approach in eliciting the client's viewpoint and goals.

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<sup>285</sup> SFT is not of course unique in this respect and the concentration on short-term work and clear goal setting is shared with many social work methods such as task-centred and crisis intervention models.

*The immediacy of the reward* for those who used it with perceived success was for some that they felt it shifted the responsibility for creating change back to the client and so the worker felt less burdened; for others it was to do with the clarity with which they elicited clients views and goals and for others it was to do with the more positive relationships they were able to forge with clients using the approach.

(ii) *Compatibility* - For all respondents, the approach was very compatible with social work ethics and values centred on client self-determination, promoting strengths and resources and treating the person with respect. The philosophy of the approach had a unanimous strong appeal in this respect. The spontaneous articulation by many respondents of the appeal of the approach being centred on its ethos suggests that it caught the imagination of many in a powerful way and effectively acted as a strong reminder to them of some of the core humanistic values of social work, even if they made the decision not to proceed with a trial in practice. It fitted with their view of what social work should be about even if their own practice conditions (or other factors) militated against adoption of the innovation.

Some of the specific interventions (especially ‘the Miracle Question’ and the focus on positives) were viewed negatively by those practitioners who did not see them fit with their style of working and indicated a lack of comfort in using them (for example, the medical social workers for whom the approach was ‘*a bit slick*’).

While many were clearly viewing it as a compatible approach for individual work, few saw it as an overarching framework for social work on both the individual and environmental levels. Workers referred to the structural inequalities which many clients suffered from and workers across the settings also saw the provision of practical help, advice and information -giving as important parts of their role.

For a small number of respondents while the approach was compatible with their global version of social work, they did not see it as compatible with their own local version of social work tailored for a specific setting. This was most evident for medical social work and fostering workers and to a lesser extent to child protection workers.

That individual orientations to practice are a critical factor in the diffusion of practice innovations has been suggested strongly by the data, and is to be reaffirmed here as a component at the individual level. That SFT itself demanded a more active role on the part of the practitioner than approaches premised on psychoanalytic or counselling theory was suggested in an earlier chapter. That practitioners demonstrated four different approaches to practice has also been outlined in the Findings chapters.

Workers who went on to adopt SFT were more likely to view themselves as what I have termed '*active change-agents*' than those who didn't.

Where SFT was compatible with other favourably-received ideas, adoption was also more likely. For some, SFT was akin to the Marte Meo method and NLP, and as Rogers has noted 'Compatibility of an innovation with a preceding idea can either speed up or retard its rate of adoption' (1995: 225).

(iii) *Complexity* – As outlined in previous chapters, respondents varied in their perceptions of the approach in relation to complexity. Many referred to the perception that it was simple and easy to understand and contained some specific interventions that could be adopted flexibly. Differences that existed between respondents appeared to be related to individual characteristics. The confirmed adopters appear to have taken to it with ease and incorporated it relatively effortlessly in their practice.

The account of one of these early adopters raised the question of whether the SFT approach was 'difficult' in itself in terms of complexity or whether helpers complicate matters by 'forgetting' core wisdoms (such as the values of respect, negotiation, encouragement and praise), when he said that he had been '*screwing it up*' by making it more complicated than it really is. The second bout of training for him was effective in reminding him to keep it simple.

However for the large group of 'undecideds', actual implementation was harder to achieve. The aspect that appeared to give them most trouble was that of balancing the concentration on the positives and exceptions with the need to be responsive to the client in terms of listening to them about the problem and understanding how bad things were. The other element that many 'undecideds' referred to was uncertainty regarding their own skills levels and ability to use it 'properly'. Confidence and experience levels appeared to be factors here.

The findings in relation to perceptions of complexity suggests that again individual or personal characteristics (such as ability, self-efficacy and a strong internal locus of control (Baldwin & Ford, 1987; Quinones, 1997)) had a bearing in how complex individuals perceived the approach to be.

(iv) *Trialability* – The innovation itself appeared to lend itself to limited experimentation, particularly given the ways in which it was 'unpacked' by most respondents. Rogers has noted that

New ideas that can be tried on the instalment plan will generally be adopted more quickly than innovations that are not divisible. (1995: 16)

Selective experimentation, however successful, was not however followed by incremental adoption of additional aspects – rather it appears that selective experimentation leads to selective adoption. It was a rare few who continued to experiment with the approach, develop their use of it and extend both themselves and the model.

The most common pattern of usage was that aspects of it were adapted or reinvented by respondents to fit their own style of practice and their own perceived requirements.

For most, SFT was not a universal approach to be used in all cases (although some practitioners did refer to adopting the mind set and incorporating the philosophy) but instead was viewed as a tool to be used in particular cases or scenarios where either worker or client (or both) were ‘stuck’. Practitioners were essentially identifying the specific cases where they considered an approach premised on individual change-work was appropriate.

It was evident that for some (such as those in specialist or therapeutic settings) this could involve many of their cases in which case it became part of their repertoire; whereas for others (such as those in child protection or fostering settings) it might only constitute a small minority of their cases, in which case they would strive to remember components they could use.

(v) *Observability* – Given that social work is such an invisible trade (Pithouse, 1987) and that it is extremely difficult to establish exactly what creates change in specific situations, the respondents in this study were understandably guarded in making claims for the effectiveness of the approach. Rogers (1995) suggests that the less observable the results of an innovation are, the slower will be the rate of adoption. In relation to a theoretical innovation (ideas-only) which in social work can only be a *partial* innovation until put into practice by the worker, the issue of observability is particularly complex.

Observability by others in social work is only possible where people are co-working and even then it is entirely imaginable that co-workers will differ in their views of what actually happened and what actually created change, if change occurs. In this respect, the confirmed adopters in this study who were single sustainers showed less reliance on external sources of validation for use of the approach than the ‘undecideds’. The confirmed adopters who had worked with colleagues and observed others use the approach engaged in a vicarious experimentation through this process.

Those in child protection work were most anxious about needing support in its use, an unsurprising finding given the anxiety engendered by such work and the pressures on them to stick to procedures and bureaucratic formulas (Howe, 1992; Buckley, 1995).

The most successful of the child protection workers in implementing the approach in the main either co-worked or had direct guidance and support from peers or managers, and in the case of one 'returnee' who adopted the approach more fully after the second bout of training, the difference appeared to be the presence of a colleague with whom she planned and then reviewed use of the approach. Colleagues may therefore make a difference not only because they offer support and guidance but also because they offer a measure of observability which is otherwise absent from most social work settings.

## **THE MARKETING PROCESS**

Marketing has a negative connotation in some academic circles because the term is narrowly construed as synonymous with manipulating human purchasing behavior for commercial advantage. On the contrary marketing activities, if they are to be very successful over the long term, must match consumers' needs with commercial products and services. (Rogers, 1995: 79)

'Therapy' is now a pervasive business offering an ever-increasing range of products to service providers and consumers. The development of new approaches, products, books, videos, training packages and conferences is for many, especially those located primarily in the private sector, a lucrative business. Marketing is not as alien a concept as we might like to think.

When SFT was first generated as an innovation in the family therapy field, it was packaged in a way that maximised its potential appeal to the audience of potential adopters as detailed in Chapter Four. Its diffusion throughout the family therapy field was also facilitated by particular factors, such as the active promotional role adopted by, amongst others, Berg and de Shazer.

Diffusion beyond its original targeted audience was also influenced by the roles and marketing strategies adopted by those acting as early product champions in the local social system of publicly-funded social services.

Approval for funding for the first Dublin SFT course in 1994 was granted following an application which not only detailed the approach and its champions abroad but also contained a 'statement' from a local practitioner (the researcher) confirming its effectiveness as a tool for social workers in the local context. Strategies for recruiting support from 'gatekeepers' ('those who control the allocation or distribution of funds', Smale, 1998: 112)) is essential in public services.

The second training fund application had the support of one product champion (the course organiser) and two other opinion leaders. While these gatekeepers were important in ensuring the release of funds, the most critical marketing process was that directed at potential adopters. Here, the significance of the peer network in the marketing process was borne out. Peer interest, approval and recommendations influenced most of the participants to seek more knowledge about SFT. The

exceptions were those isolated individuals, either through location or other factors, who had no prior knowledge or interest in the innovation. Even here the peer network held up as it was through a local professional association news-sheet that these participants heard about the approach.

The marketing of SFT emphasised the flexibility and adaptability of the approach. As noted in an earlier chapter, the course notes ended with the message that ‘Solution focused brief therapy embodies a set of principles which can be adapted to many areas of work outside the strict confines of therapy’. The research illustrates the extent to which even prior to the training itself, potential adopters focused on specific aspects of its imagined appeal – the brief label, the solution label, the focused label and the therapy label – and these selections appeared to be related to the particular perceived needs and expectations that existed for workers in various settings and contexts. The unpacking process that was taking place even prior to the training event was facilitated by the marketing process itself which emphasised its versatility.

#### **THE MEANS OF TRANSMISSION**

How an innovation is marketed and packaged is one element of the diffusion process. Another is the route(s) used to introduce the innovation into a specific social system. Rogers concentrates on communication channels as ‘the means by which messages get from one individual to another’ (Rogers, 1995:18). Diffusion research to date suggests that the interpersonal networks through which subjective evaluations of an innovation are exchanged among individuals in a system are of critical importance, and are relied upon more by potential adopters than forms of mass communication. Early product champions, nonetheless, have to make decisions regarding the means to be used to communicate the innovation to potential adopters. By considering the ‘*means of transmission*’<sup>286</sup> used to spread news of an innovation, both the formal event (such as the short course) and the informal social networks operating within the local social system (and existing prior to and following a formal event) can be considered.

#### ***The Short Course***

In considering how effective this short course was as a means of transmitting the innovation to the potential adopters and how significant a role it played in the innovation-diffusion and adoption process, it is necessary firstly to locate the course within the temporal innovation-diffusion process and secondly to draw on literature from learning theory to illuminate both the potential advantages and limitations of short courses.

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<sup>286</sup> ‘Means of transmission’ is not intended to infer that the targeted audience are considered passive in the process. It is merely used to denote the communication channels chosen to transmit news of the innovation into a social system.



### *The short course in context*

In the Irish social work field at the time, as outlined in Chapter Two, continuing professional development was individually, rather than organisationally, led. Training officers did not exist in the larger organisations, such as health boards. With the exception of some college-based, advanced 'long courses', training opportunities were few and far between. For this very reason, the SFT short course was likely to be warmly received. Where training opportunities did occur, it was at the instigation of small groups of practitioners and managers who usually took on the organisation of such events as unpaid extra tasks. Rewards came in the form of status and gratitude from peers if the event was deemed successful and useful. If it was not, then reputations could be diminished. There was an element of jeopardy involved for those who organised such initiatives – it was not for the fainthearted. Smale's (1998) description of the role of 'product champions' and the importance of their social and professional networks would suggest that the fact that the product champions were in this case influential managers and colleagues of those they were seeking to influence would have acted as an extra positive factor in maximising receptivity on the part of the potential adopters. Although the point has been laboured by now, innovation-introduction by established opinion leaders and product champions within the professional group is probably a great deal more effective than that from either organisational higher managers, organisational trainers or external 'change –agents' alone.

### *'Training' or 'Consciousness-Raising'?*

The 1995 short course was the second course in SFT to take place in the locality. Following on some 18 months after the first Irish event, a degree of momentum and interest had built up in the local social work network, fuelled (as is evident from the findings) by positive reports from early adopters and the perception that SFT was 'breaking news' internationally, coupled with the (unusual for these times) provision of funding from the largest employer for 'training' in the approach. That it was an introduction to an optional practice innovation, peer-led rather than organisationally imposed, appear to have also been factors likely to increase appeal. These contextual conditions created a particularly positive pre-training environment; but is it accurate to call it a 'training course' as such?

Smale (1998) distinguishes between six different means of innovation-introduction available to organisational managers and of relevance here is the distinction between Consciousness Raising Events and Training Courses. The former, he maintains are useful for illustrating the

major dimensions of a new approach to practice' [as the] 'advantages of an innovation and its achievements as demonstrated by early evaluations can be communicated to a wide variety of audiences. The uninitiated or the uninvolved can be informed of what the choices are (pp. 203-4).

But, he also warns that they can only be the very first step in the spread of a new method because they are of most use to early adopters and opinion leaders but have little impact on others: ‘Product champions and potential early adopters are more likely to want to attend such gatherings and make better use of the information, and the contacts they make (p. 204).

‘Training events’ on the other hand (which include the short course and skills workshop format of a few days length) while often gratefully received by staff ‘hungry to hear how they might set about developing their skills and knowledge’ (p. 206) are limited when it comes to establishing new behaviours or tackling significant change in attitude or role without ‘time for discussion, research analysis and practice (in the sense of trial and error learning) ... an infrastructure of support materials, mentors and so on’ (p. 207).

Given the early stage of the innovation-diffusion process at which the 1995 short course took place, it is probably more accurate to consider it as an event which acted both as a consciousness-raising event for some and as a training event for others who had already some prior knowledge. As it served different purposes for the participants, so also it had different effects.

#### *Training-related factors*

As outlined in earlier chapters, this short course fulfilled the criteria for an ideal training event in relation to the presenter and range of teaching methods used. It was generally very well-received and the trainer came in for special mention by many. Of particular note to participants was the fact that he was practising the approach he was teaching and was able to both show videos of his own work and give examples from practice. He was therefore able to demonstrate that he was an expert practitioner as well as a trainer. It is not uncommon for external trainers and consultants to be theoretically well-versed in particular practice methods, perhaps even researchers in them, but not to have experience of using the actual approaches themselves. The feedback from these training participants is that it makes quite an impact on them if trainers can demonstrate expertise in practice as well as teaching skills.

Respondents varied in their perceptions of the level of heterophily<sup>287</sup> that existed between them and the presenter. Rogers (1995) suggests that a certain amount of heterophily is necessary, as a ‘change-agent’ such as a trainer needs to be different in being more technically competent than the audience of potential adopters but they also need to be homophilous<sup>288</sup> to the degree that the potential adopter can relate to them and their experience as being roughly similar to their own. Some of the respondents who either did not adopt or who had doubts about their ability to do so

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<sup>287</sup> ‘*Heterophily* is the degree to which pairs of individuals who interact are different in certain attributes.’ (Rogers, 1995: 287).

<sup>288</sup> ‘*Homophily* is the degree to which a pair of individuals who communicate are similar’ (Rogers, 1995: 286).

referred to the trainer's level of expertise and skill as being *too advanced*. Some then made the decision that it was his skill rather than the innovation itself which produced results; others wondered whether a high level of skill was needed in order to use the innovation.

That the training event was run by only one presenter is worth considering, as an alternative common format is for two presenters to jointly run short courses. Because the trainer had adopted the approach in his own practice, published on it and created his own version meant that he presented his own *particular interpretation* of SFT. In this way the training event influenced the way in which participants interpret and understand the theory, as different outcomes or 'readings' of the approach may have resulted from participants only reading the textual versions of this practice innovation or if they had been exposed to two presenters with different versions<sup>289</sup>.

That other versions are possible can be made more apparent when two trainers present, especially if a conscious effort is made to do so but for newcomers to the approach receiving one coherent interpretation based on the trainer's own experience is probably an advantage.

Given that the short course had so many positive features and was so well-received, it can be said that training –specific factors were not in this case significant negative influences on outcomes. If anything, the training-related factors were likely to have *maximised* the chances of the innovation being adopted. This then gives us a clearer view of how practitioners fare with innovations in the transfer back to the workplace and what individual, environmental and innovation-specific factors come into play. A key question which does remain however is:

*What was the significance of this training event in relation to the diffusion and adoption of SFT in the local social work context?*

#### *The significance of the short course*

The course acted both as a consciousness-raising event and as a specific therapeutic skills training course in a practice innovation. The significance of the short course needs to be assessed on *the macro-organisational, micro-organisational and individual* levels.

*The Individual level* – the findings indicate that it impacted in three different ways on individual participants.

The event can be said to have acted as a '**catalyst**' for those with prior interest, moving them into a position where experimentation was more likely rather than less. It built up the momentum for

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<sup>289</sup> That SFT is amenable to a range of interpretations is evident from the literature review where the conclusion was reached that it is probably more accurate to refer to the family of SFT approaches at this stage.

these participants, gave them time to envisage using it in their own practice and gave them some confidence through practising skills and exercises. This movement was most often typified by the respondent leaving the course with some clients already in mind to use the approach with.

The course acted as a ‘**confirmation**’ for those who had already adopted the approach. This effect was of particular significance to those single-handed adopters who were isolated in their use of the approach. The short course for them acted as a forum both for reviewing their own practices, and as a networking opportunity for early adopters to link with like-minded innovators. That this group of early adopters returned to another short course instead of using or creating other networks is worth noting and may be a comment in itself on the local social system and the absence of networks for innovators in the social work/social care field.

The training event can also be said to have acted as a ‘**seed**’ for interest to grow and develop amongst those who came without any prior interest in or knowledge about the innovation. Some of those who attended were intrigued, interested or challenged by the approach but made decisions not to proceed with implementing it in practice for the time being. Nonetheless, there were suggestions in the accounts of some that they were ‘storing up’ the approach and may return to it when other factors had changed (such as developmental stage; agency context, agency conditions).

The short course can be said to have been successful in both supporting early adopters in their use of the innovation, in moving others into experimenting with the innovation and in placing a seed of interest in others who had previously been unaware of its existence. It is hard to imagine how this optional practice innovation could have been more successfully diffused at this early stage of the process<sup>290</sup>

*The Micro-organisational Level* – the course can be said to have been successful in raising awareness of SFT in all the area teams of the health board who were circulated. Areas differed in response to this invitation and this was an illustration of ‘patches’ of the social system where interest in the innovation was already seeded and areas which were ‘greenfield’ sites. The differential effect of the short course, as evidenced by the clusters of adopters and non-adopters at the time of interview, is an example of the momentum which can be built up around an innovation if sufficient members of a local system have adopted or are interested in adopting it and the parallel momentum against adoption if sufficient members of a local system decide against adoption having engaged in initial knowledge-seeking. The data relating to the one area which accounted both for the largest number of attenders and the largest group of adopters suggests that in this area adoption had almost become a system norm. But had ‘critical mass’ been achieved? Critical Mass has been

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<sup>290</sup> Smale (1998) does suggest other workplace-based activities necessary to implant an innovation into particular organisations but in this study we will continue to concentrate on professional-group introduction.

defined as occurring ‘at the point at which enough individuals have adopted an innovation so that the innovation’s further rate of adoption becomes self-sustaining’ (Rogers, 1995: 313). Given the absence of a longitudinal aspect, an evidence-based answer to this question is not possible from the findings of this study but the signs were not encouraging. In the intervening period between short course and research interview, three of the eight adopters from this area team had moved location and changed role. Only one of these had sustained use of the innovation through the change suggesting that adoption patterns were still fragile at this point of the diffusion process and easily dislodged. The relative stability or mobility of staff groups is clearly an issue which impacts on diffusion possibilities. The accounts of all practitioners who had moved indicate how their need to ‘read themselves’ into their new situations displaced their interest in SFT, at least temporarily.

*The Macro Level* – did the course have any significant impact at all on this level? Taking the organisations involved, while data was not specifically collected from sources other than the direct participants, there was no evident impact on the wider organisations<sup>291</sup>. This is in one way unsurprising, but in another way, disappointing. Unsurprising, as for an optional practice-innovation focused on one specific potential role within social work (that of a therapeutic change agent) organisations, it might be considered, should discreetly support practitioners who in their professional judgement deem it to be a potentially useful tool. Disappointing, as evidence emerges from other contexts, such as child protection services in Australia (Turnell & Edwards, 1999) and the USA (de Jong & Berg, 2001) that some statutory services have adopted SFT as the basis for a refocused child protection service concerned with working with carers to strengthen families. In the Irish context, SFT and Child Protection were both innovations which entered the social work system at around the same time. Child Protection, for reasons outlined in Chapter Two, was a far more powerful innovation. Indeed it was of a completely different magnitude which not only commanded significant resources, had public, political and organisational support but which was essentially an ‘authority innovation-decision’ (Rogers, 1995: 372: ‘a choice to adopt...made by a relatively few individuals in a system’), organisationally adopted and imposed on health board employees. Within the health boards, child protection practices were being introduced such as the requirement to notify Gardaí (police) of all suspected abuse and neglect allegations (DoH, (Ire.) 1995) which challenged practitioners’ attempts to work in a solution-focused way with clients (Shine, 1997). On a macro-level therefore SFT can be said to have lost out to Child Protection practices centred on more formalised reporting and assessment processes, and as in the UK (Howe, 1993), is an example of therapeutic practices being outmanoeuvred by the swing towards child welfare practices premised on notions of surveillance and protection.

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<sup>291</sup> Although this conclusion does need to be tempered with an acknowledgement that since the research interviews, individual practitioners still interested in SFT have either lobbied new training managers or team leaders and senior managers for resources to develop workplace supports.

*The macro-level* can also be defined as the professional network of social workers who are not necessarily members of the same formal organisations, agencies and specialisms but who nonetheless are potentially potent forces and influences in the professional field. The very fact that this short course took place and brought together practitioners with like-minded interests in therapeutic work can be said to have established seeds at the macro-level in legitimating this area of practice and in providing networking opportunities for early adopters. The establishment of improved communication channels between practitioners in different settings and the strengthening of professional bonds could in itself be one antidote to the risks of creeping functionalism on the part of workers but the absence of a longitudinal tracking of this process renders it a phenomenon of some interest but one which requires further investigation.

#### *The Timing of Large-Scale Inter-Agency Courses*

Perhaps, as Smale (1998) maintains large-scale training events such as this are only viable as means of transmission at early stages of an innovation's introduction into a social system?

The fact that an event of this scale was not repeated (but instead supplanted by a number of smaller training and consultation initiatives at local level) would indicate that this is the case for the period of time studied. That large introductory workshops might be necessary over a longer period as new workers join agencies and movement of staff takes place is probable. As innovations tend to themselves develop over time also indicates that follow-on large events can be useful.

In this case, the account of the course organiser also indicates that her ability (and willingness) to continue as a 'product champion' decreased somewhat after organising this second large-scale course. Events also overtook her to some extent as the organisational focus tightened even more onto child protection priorities and more preventative frontline working practices were replaced by Family Support initiatives provided by separate teams of workers.

#### *Social networks*

The social system can be viewed as a collective-learning system in which the experiences of the earlier adopters of an innovation, transmitted through interpersonal networks, determine the rate of adoption of their followers. Communication channels are therefore important in the diffusion of news about an innovation, and in providing potential adopters with a subjective evaluation of an innovation from near-peers but the fact that communication channels exist does not mean that they are necessarily *open* or *used*. This variable of the diffusion process will be analysed further as the *peer influence process* in later sections.

## **THE TRANSFER PROCESS**

That a short course *should not be* considered as a ‘stand alone’ event is evident from Smale’s reservations above. That it *cannot be* is borne out both by organisational training theory on ‘the transfer process’ (Baldwin & Ford, 1988) and by experiential learning theory (Kolb, 1984; Bilson, 1993) showing the need for concrete experience and abstract experimentation as well as review and reflection activities. But for optional practice innovations, how should follow-on support be constructed?

### ***Levels of expertise***

It was suggested in the literature review that in order to develop appropriate training strategies (including follow-on support), an innovation needs to be assessed to establish which level of learning (Bilson, 1993; Smith *et al.*, 1997) is required to use it. But the findings from this study show that practitioners engaged with the innovation at different levels and that this was *learner- and context- related* rather than innovation- related. Whether the practitioner adopted it at Level One (learnt some set behavioural responses); Level Two (engaged with it on a more complex level while determining selectively where it might best be used) or Level Three (where challenges and changes to a set of beliefs and assumptions occurred) depended on particular factors.

*Individual-specific* ones were:

- the existing orientation or philosophy of the practitioner and the perceived congruence or dissonance of the innovation to that;
- the developmental stage of the practitioner related to their level of expertise (did they have novice expertise where problems were still considered in superficial terms? Routine expertise where they already knew how to deal with well-defined problems? or adaptive expertise where they sought unique solutions to complex cases? (Smith *et al.*, 1997));
- abilities to think creatively and flexibly and conceptualise problems in a range of ways.

*Environmental-specific* factors were:

- The opportunities to practise the approach and experiment (in order to achieve Level 2 or 3, ‘calibration’ (‘repeated practice in situations which are themselves essentially unique’, Bilson, 1993: 49) is necessary;
- The availability of supports, either in the form of a line manager or a colleague with which to review and reflect on experience;
- The extent to which there existed a learning environment where innovation, experimentation and reviews of existing practices were tolerated or actively welcomed.

*(b) Support strategies*

These findings suggest that the types of support strategies needed to maximise learning opportunities vary depending on both individual and environmental factors. While there is an automatic focus within the UK organisational and social care literature on the role of the line manager, and a repeated wisdom which recites the importance of enlisting them as key supports (Horwarth & Morrison, 1999; Smale, 1998; Reid & Barrington, 1994), this study suggests that this is neither always possible nor always required and is to some extent conditional on the *nature* of the innovation.

Confident, experienced practitioners will not always view the line manager as either valid or valuable as a resource on practice methods; nervous or busy line managers will not always make themselves available as a resource. Practitioners will and can establish supportive alliances with colleagues to support practice innovation. The ‘pairing’ system spontaneously adopted by practitioners in three health board areas proved very effective and was more successful as a support system than the more ambitious support groups planned but abandoned in several other locations. While the ideal scenario of an active and confident manager coaching and supporting practitioners in using new practice methods still holds, in this study it was the exception rather than the rule. Other strategies were developed where practitioners do not wish to use, or managers do not wish to engage, in joint activities.

**INDIVIDUAL CHARACTERISTICS**

The nature of social work is that it is an activity based on interpersonal interaction. Although the focus of social work varies and encompasses interventions on the macro and mezzo as well as the micro level, it is evident that in many contexts, including the Irish one, interventions at the micro level with either individuals, couples, families or groups are a central part of social work practice (Compton & Galaway, 1994; Skehill, 1999; Fook *et al.*, 2000). Practice methods, such as SFT, which concentrate on the dynamics of interaction between practitioner and client are of particular relevance to social work for that reason. Using SFT requires more than the following of a formula but also requires both general interpersonal skills and specific therapeutic skills.

***Ability***

Studies exist (DHSS, 1978; Sinclair & Walker, 1985) which strongly suggest that differences exist between practitioners in terms of ability and effectiveness. Sinclair and Walker (1985) found that following training in task-centred casework, practitioners in the same settings differed greatly in their ability to use the approach to achieve positive outcomes. More recent meta-analyses and overviews of studies into therapeutic effectiveness (McKeown *et al.*, 2001; Hubble, 2001) indicate



that therapeutic technique and the quality of the helper-client relationship are two of the four most significant factors (the other two are client variables and client hopefulness).

The findings from this study show that practitioners varied greatly in their ability to use the approach successfully according both to their own criteria and that of the researcher. Comparison of the successful and non-successful adopters, as outlined in previous chapters, demonstrate that neither setting nor experience levels could in themselves account for these differences although both are factors which have an influence. Some sub-dimensions of ability can be considered.

### ***Therapeutic role(s)***

Different professional interventions demand different skills and qualities on behalf of the practitioner. Interventions focused on engaging clients in therapeutic work require both general interpersonal skills and specific therapeutic skills.

Whether *general* interpersonal skills and *specific* therapeutic skills are largely a matter of innate personal characteristics or can be developed through training is a matter which remains contested. Findings that training *in itself* does not necessarily increase therapists' intervention skills led one family therapist trainer to conclude that

It is clear that we achieve reasonable outcomes in training individuals to think about therapy, but how well this is translated into advanced professional practice is another issue that has not been addressed. (Street, 1997: 107)

Street concluded that personal characteristics at least play a part in the equation. This study can add the contribution that therapeutic modalities call for different qualities and stances on the part of the practitioner, and these requirements may vary in their congruence to a practitioner's personal style or orientation. This can be considered a development of theories which assert that essential therapist-characteristics form the bedrock of the therapeutic encounter (Rogers, 1957; Howe, 1993) but which don't explicitly distinguish between different therapeutic modalities.

SFT as one particular therapeutic modality appears to fit best with practitioners who are comfortable adopting an '*active change-agent*' approach, part of which is an ability to retain both optimism and confidence during the helping process. Others in the study fitted into one of three other roles of *passive-witness*, *agency-functionalist* or *reactive-functionalist* although these orientations were constructed only in relation to this innovation and their reaction to it—they cannot therefore be considered to be truly accurate depictions of their overall orientation.

It is possible that some of the practitioners in this study who were successful adopters had altered their stance to one of an active change-agent *as a result of* successful experimentation with SFT,

rather than having it prior to experimentation but the accounts of the non-adopters do suggest that their dislike of the active role adopted by SFT practitioners was a significant deterrent.

Whilst this study did not examine skills level *changes* as such, the findings suggest that short courses focused on developing skills in a particular method if followed by practice implementation *which is perceived to be successful* by the practitioner at the least enhances practitioners' *sense of confidence* in their ability to use therapeutic methods at least in the medium-term (12-18 months) period following a short course. The issue of whether this change is sustained over longer periods of time remains unknown but what was evident was that for most successful adopters, conscious experimentation was replaced over time with incorporation of particular SFT ideas and strategies into their own personal framework.

### ***The developmental component***

Following Secker's (1993) and Fook *et al.*'s (2000) work on the developmental processes involved in beginning practitioners' use of formal theory, findings from this study suggest that there is a developmental component to the process of experimentation with new approaches in the post-qualifying context and with outcomes relating to adoption of innovations following experimentation.

Utilising a different methodology from Fook *et al.*, it was possible to examine the experiences of a cross-section of practitioners at different developmental stages exposed to the same approach at the same time. Most who did proceed to experiment with the approach in practice consciously selected a case and methodically tried to follow the approach in a formulaic manner (akin to Secker's cookbook approach) and broadly following Kolb's (1974) experiential learning cycle. However, differences existed between the recently qualified and more experienced practitioners in the relative weight of importance that they attached to different aspects of the cycle. The more experienced were markedly more confident about selecting aspects they would use and rejecting others that they wouldn't *without a trial* whereas the less experienced workers appeared *to need the trial* in order to make judgements about selecting aspects to use or reject, or to identify the scenarios where they would use it or not. The significance of the trial therefore differed depending on the developmental stage of the practitioner. Why should this be?

While studies of professional development, both outside and within the field of social work, cover aspects such as the processes of professional socialisation, learning and skills development, and the impact of professional training on areas such as the use of formal knowledge and changes in attitudes and values, they throw little light on why this difference should exist<sup>292</sup>. The accounts of

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<sup>292</sup> Fook *et al.* (2000) found that practitioners changed over the first three post-qualifying years in the use of formal theory from a position of little use in year one, through to a 'rediscovery' of the usefulness of

these practitioners suggest that their need for a trial differed, and this I suggest is due to the lack of confidence most of the more recently qualified workers held in their own personal maps for practice and intuitive abilities<sup>293</sup>. The literature on counselling and on supervisory dynamics in the helping professionals contain conceptualisations of ‘trainee development’ of relevance here. Hawkins and Shohet (2000) describe a four-stage process<sup>294</sup> based on the trainee’s development of objective criteria by which they can assess the quality of their own performance and how this relates to the level of dependence on others such as peers and supervisors as ‘assessors of good practice’. Following this, it can be proposed that practitioners who are confident (certain) that they ‘know’ intuitively what is required in particular situations will be less dependent on ‘proving’ this through actual practice experimentation, whereas those who are less confident (uncertain) of their practice knowledge or intuition will seek validation of their views through their own practice trials, along with or instead of other forms of validation such as consultation with peers, guidance in supervision, reference to texts<sup>295</sup> etc. Whether or not the more experienced practitioner is actually more competent is beside the point – it is *their belief* that they are which is important.

Not all experienced practitioners made these judgements with such certainty however. Some made more provisional judgements and remained more open-minded or flexible (akin to adaptive expertise). The point is however that *if* potential innovations are filtered firstly through the lens of prior practice experience to which undue weight is attached, then there is the risk that a practice experiment is approached with a less open mind and with a selective perception that seeks only to confirm the pre-existing opinion. The value of a practice experiment therefore varies depending on how open or closed an individual is to learning from both the experience and perceived results of the experiment, and this is affected by the individual’s level of certainty generated from confidence in their own practice wisdom and intuitive abilities. The greater the degree of certainty generated from confidence in one’s own practice wisdom and intuitive abilities, the less significant the trial becomes as an essential component of the learning process. That practitioners are more likely to

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theory and a more conscious attempt to use it in practice at the end of year two/throughout year three to little usage again amongst more experienced workers.

<sup>293</sup> That it is not an absolute rule suggests that individual differences exist – the one striking exception was the newly-qualified worker in Area 5 who had an ability to assess situations in a complex rather than surface manner and who demonstrated a high level of both competence and confidence in the ability to apply the method appropriately.

<sup>294</sup> Level One: self-centred – supervisees anxious and insecure about their role and their ability to fulfil it, lacking insight but also highly motivated – stage characterised by dependence on supervisee. New trainees have not had the experience to develop grounded criteria on which to assess their performance and consequently can feel very dependent. Analyses remain superficial or partial. Level Two: client centred – Here the supervisees have overcome their initial anxieties and begin to fluctuate between dependence and autonomy, over-confidence and being overwhelmed. Work with clients becomes less simplistic and interventions are used with more discrimination; Level Three: process centred – increasing professional confidence with only conditional dependency on the supervisor; greater insight and stable motivation; adjusts approach to suit client; ability to see client in wider context; Level Four: process in context centred – ‘master’ status – personal autonomy, insightful awareness, personal security, stable motivation – deepening development of ‘wisdom’ (Hawkins & Shohet, 2000: 603).

<sup>295</sup> Although reading is generally thought to be a ‘low-priority’ activity for most social workers.

become confident as they become more experienced is suggested both by the literature and by these findings, but there were also some practitioners with a high level of confidence in their practice who were relatively inexperienced and some highly experienced practitioners who lacked confidence, suggesting that confidence may well be a factor dependent on both personality characteristics and experience quality and length.

### ***Confidence-internal or external loci of control?***

Confidence (related to level of experience) also emerged as an individual variable of significance in relation to differential adoption rates. The more recently qualified practitioners were in general more sensitive both to views of managers and of peers towards the innovation. They understandably looked for both more approval and active support and guidance but those most engaged with the innovation then created support systems of their own if they were lacking.

Reid and Barrington (1994) suggest that workers may vary in their adherence to a *conformist or non-conformist* stance in relation to organisational mandates and directions – those with a rebel tendency can be considered to be more likely to adopt an innovation which challenges system norms but to do so in a manner which will ensure that the homeostasis of the social system remains intact, i.e. they may challenge the system norms but will ensure that they do not challenge them to the point of being excluded from the social system. The early adopters of an innovation (Rogers, 1995) within a social system can be thought of akin to non-conformists as they place less emphasis on the opinions of others.

Baldwin and Ford (1988) found that *personality* factors (specifically a high personal need for achievement and a strong internal locus of control) were indicators of a successful transfer of learning from training courses to work practices. The findings from this study bears out the importance of a strong internal locus of control for those who are either early adopters of an innovation or those who are adopting an innovation at variance with system norms (Rogers, 1995). While the importance of the individual's level of desire to achieve did not emerge as a factor in this study, it cannot be claimed that it is irrelevant.

This individual characteristic (of a strong internal locus of control) appears to be of more significance than a non-conformist tendency as such. Furthermore it affected how individuals interacted with their social networks. Workers varied (regardless of setting) in the extent to which they relied on their own or others' judgements or influences regarding the innovation. Some were happy to go ahead and innovate, if SFT fitted with their conceptualisation of social work; others appeared to listen more to what others said before deciding their own position on it. A certain level of confidence and a strong internal locus of control were of particular important for *single sustainers* of the approach. Rogers (1995) would hypothesise that those who are more reliant on the

opinions of others are either ‘late adopters’ or ‘laggards’ who will only adopt an innovation when it has more or less become a norm of the social system to do so but the limitations of the methodology adopted in this study means that this assertion cannot be tested.

### ***Surface versus Complex analytical skills***

Distinctions could be made between practitioners who adopted a surface approach to problem analysis and those who adopted a more sophisticated multi-layered analysis. Practitioners’ *cognitive abilities* in assessing practice situations, a matter of developing expertise in exploring, processing and framing relevant data and hypotheses, is of critical importance because it is upon such ‘frames’ that intervention strategies are decided. Some practitioners in this study looked only at the surface dimensions of cases, globally categorised as ‘child abuse cases’, ‘addiction problems’, ‘multi-problem family’. Others referred to more case-specific subtle, but significant factors such as levels of motivation, acceptance of a common problem frame, levels of self-esteem. The latter made intervention decisions in relation to their use of SFT based on a more sophisticated analysis of relevant factors that denotes generic adaptive expertise (Smith *et al.*, 1992). Similarly Fook *et al.*’s description of the ‘expert’<sup>296</sup> (as opposed to the ‘experienced’) fits in with the concept of complex rather than routine or simplistic analytical skills, combined with a creativity which arguably those who successfully transferred the innovation to their practice needed in order to try something as different as SFT.

### ***Uncertainty and creativity***

Rogers (1995) emphasises the ability to cope with uncertainty as being a necessary skill for early innovation adopters who need to have a certain degree of courage to strike out by themselves. Developmental stages appear to be important here as most of the more recently qualified practitioners were not only more likely to analyse situations in a surface rather than complex manner, but were also more anxious about the risks of experimenting with the new approach. They were more likely to resort to agency rules and procedures to guide their practice and less likely to demonstrate the ability to think and act creatively. In the main, they certainly did not want to take risks and this is understandable in the context of developmental theories of professional expertise (Hawkins & Shohet, 2000). One successful early adopter who was a single sustainer in a Health Board area and isolated from supports demonstrated through her case examples how the *ability* to cope with uncertainty and the *art* of creativity are linked (Appendix D: 6).

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<sup>296</sup> ‘The expert practitioner is one whom we would expect can take risks, and act beyond the call of duty ... Reaching the expert stage may involve factors such as an openness to new ideas, a preparedness to think creatively, a frame of reference which frames problems in complex, as opposed to routine ways’ (p. 180).

### *Optimism/hope*

The successful adopters had an extra quality of optimism that distinguished them from the others. Whether the optimism was an innate aspect of personality, there prior to exposure to SFT, or whether it was a *product* of exposure to SFT and/or successful experimentation is an intriguing question but almost impossible to answer in this study. Seligman's (1998) work into 'learned helplessness' and 'learned optimism' suggests that while individuals might have natural leanings towards either a pessimistic or optimistic style of thinking, these are not fixed attributes but can be modified through cognitive-restructuring. Can short courses and/or exposure to particular ideas act as effective exercises in cognitive restructuring?

The data from this study considered in the light of Seligman's work, would suggest that exposure to particular ideas, depending on the types of messages conveyed in the specific ideas, can raise levels of optimism and hopefulness temporarily but that other factors impinge on whether this shift is sustained.

Seligman maintains that there are three different dimensions to the explanatory styles of optimism or pessimism: Permanence<sup>297</sup>, Pervasiveness<sup>298</sup>, and Personalization<sup>299</sup>. The *permanence* dimension determines how long a person gives up for following a setback or failure. Permanent explanations for bad events produce long-lasting helplessness and temporary explanations produce resilience. Universal explanations produce a *pervasive* helplessness across many situations and specific explanations help to limit helplessness. While *personalization*, and the extent to which blame is internalised controls how you feel about yourself, permanence and pervasiveness control what you do-how long you are helpless and across how many areas of life.

*Hope* is a product of two of these features – pervasiveness and permanence.

Temporary causes limit helplessness in time, and specific causes limit helplessness to the original situation. (Seligman, 1998: 48)

SFT coincides quite remarkably with the features of a more optimistic style of reasoning. It concentrates on strategies to identify areas of life where the client is functioning well or adequately,

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<sup>297</sup> People who give up easily believe the causes of bad events that happen to them are permanent; people who resist helplessness believe the causes of bad events are temporary. 'Failure makes everyone at least momentarily helpless...It hurts, but the hurt goes away- for some people ... For others, the hurt lasts ... They remain helpless for days or perhaps months, even after only small setbacks' (p. 45).

<sup>298</sup> 'People who make universal explanations for their failures give up on everything when a failure strikes in one area. People who make specific explanations may become helpless in that one part of their lives yet march stalwartly on in the others...The optimist believes that bad events have specific causes while good events will enhance everything he does. The pessimist believes that bad events have universal causes and that good events are caused by specific factors' (pp. 47-8).

<sup>299</sup> 'When bad things happen, we can blame ourselves (internalise) or we can blame other people or circumstances (externalise). People who blame themselves when they fail have low self-esteem as a consequence ... People who blame external events do not lose self-esteem when bad events strike' (p. 49).

highlights the exceptions to the problem when the client was in control rather than feeling controlled, and compliments the client on areas of their life which are going well and for which they can take credit. Problems are viewed as temporary phenomena and attention is focused on building concrete, specific goals which are realistic and achievable. The underlying message to practitioners is optimistic –clients have resources and strengths which helping professionals miss if they adopt totalising pessimistic explanations for their difficulties. One implication of the findings of this study, in the light of Seligman’s theory, is that explanatory theories which practitioners adopt, to make sense of the difficulties which clients present, affect their levels of hope and optimism. Contrast those theories premised on deterministic thinking (such as biological explanations) with those which focus on shifting (and shiftable) behavioural patterns and cognitive processes (such as cognitive-behavioural therapy and SFT) and consider their connection to Seligman’s theory: ‘Finding temporary and specific causes for misfortunes is the art of hope ... Finding permanent and universal causes for misfortune is the practice of despair’ (Seligman, 1998: 48).

That participants on the training course were struck by these ideas was obvious in the accounts of many respondents. Hopeful, optimistic, positive were three of the most frequently cited qualities of SFT. What may have been less apparent to them was how important their own attributional theories might be in how they approach clients. Most of the respondents were at least temporarily buoyed up by the hope that the approach appeared to offer. They described feeling energised and positive towards their work and an underlying theme for some was the belief that this made a difference to clients, and possibly to outcomes.

Those who did not favour the approach cannot all be said to be less optimistic than the SFT advocates, merely that they did not accept that SFT could possibly make a difference to their practice and clients, and this is obviously a valid position. There were also those who indicated they were so stressed by conditions in the work place that they lacked hope and interest and for them a certain degree of pessimism may indeed have been functional<sup>300</sup>.

An outstanding question from this study is therefore the issue of whether an optimistic stance predisposes an individual towards successful adoption of this approach or whether using SFT predisposes an individual towards an optimistic stance. A second outstanding question is the nature and level of impact a worker’s degree of optimism has on outcomes with clients.

We hope because without hope we must despair. As such, the capacity to hope is a vital coping resource. (Lazarus, 1999: 675)

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<sup>300</sup> Studies have been reported which highlight the value of ‘defensive pessimism’, where ‘anxious people lower their expectations and imagine the worst outcomes. This actually quiets their anxiety, allowing them to then plan and act effectively’ (*Psychotherapy Networker* (2002) Issue 1, p. 15 – report on American Psychological Association symposium on ‘The (Overlooked) Virtues of Negativity’).

## THE SENSE-MAKING PROCESS

Fook *et al.* (2000) describe how practitioners create their own theories or 'ways of knowing' from an amalgam of different forms of knowledge *and* experience. While this process is limited in their text to 'experienced' practitioners, the findings from this study suggests that the process of sense-making and building of personal models or theories, is common to all practitioners although more recently-qualified ones probably rely initially on a less complex analysis of practice situations and are more dependent on peer and supervisor approval. The practice examples provided by these respondents and their assessments of when and where they might use, or draw on SFT, illustrates how sets of 'rules' are built by practitioners which then become maps to guide their use of that theory or framework. They do not necessarily become fixed or absolute guides as they remain open to revision (or abandonment), depending on the perceived requirements of practice realities and their own continued experimentation. If follow-on support and group reviews are offered to practitioners in the workplace, then this sense-making process may become a collective rather than an individual process but in its absence, it remains essentially a subjective evaluation neither shared nor evaluated by others.

### *Prior expectations*

The majority of participants in this study came to the short course with some prior knowledge of SFT (be it positive reports from peers; presentations on its use by colleagues, or some written materials received) and they can be considered to have made some initial assessment that it *could* be of relevance to them- hence their decision to seek more knowledge about it and attend the training course. The assessment process therefore, for most, did not start with the course itself (the formal means of transmitting the innovation) but preceded it through the formal (such as team meetings and supervision) and informal communication channels contained within the social system of which the respondents were members. Rogers' concept of 'prior conditions' was borne out as an important variable and of particular relevance was that of 'felt needs/problems'.

Quite simply, those who had identified gaps or needs in their own practice were more likely to engage actively with the approach and consider how to tailor it to their needs. For the participants who fell into this category, this initially related to clients or cases where their usual approach was not working or where nothing appeared to be working. The term '*stuck*' was used again and again by practitioners to describe these situations and this fits with Harrison's (1991) hypothesis that practitioners are most likely to engage in a 'creative heuristic search' when tried and tested practices have failed. What these practitioners did essentially, with varying degrees of sophistication, was 'test' the innovation with their most difficult cases.



### ***The process of experimentation***

As outlined in an earlier section, respondents varied in their approach to the significance of practice experimentation, and individual characteristics of developmental stage and locus of control were variables which impacted on this.

That practitioners can only really make sense of a practice innovation by trying it out and making it their own, to move from 'theoretical knowledge' to 'personalised knowledge' (Eraut, 1994) appears to be established knowledge both from studies of professional competence and experiential learning theory. However, the findings from this study that experienced practitioners are more likely to make an early provisional judgement without the need for a trial show that the processes of meaning-making are affected by developmental stage also.

### ***Patterns of adoption***

Practitioners also varied in what they took from this 'ideas-only' innovation. A minority of experimenters and adopters went for the full package of SFT as both a philosophy and a complete therapeutic model; most adopted either the philosophy or selected techniques. Individual and environmental factors both appeared to play a part here but the essential process appears to be the individual's own subjective assessment based on their perceptions of agency conditions, client needs, their own abilities and their interpretation of the social work role.

### ***Existing orientation***

Individual respondents varied in relation to the strength of their existing orientation and the impact this had on the sense-making process. Some appeared to be still struggling with either an underdeveloped personal orientation to practice (such as some of the recently qualified practitioners) or a highly developed well-established orientation to which SFT was antithetical (such as some long-qualified practitioners who described their training as rooted in psychodynamic thinking). Some others who adopted it quickly described how it was like a process of 'coming home' because it fitted so well with their existing orientation to practice.

### ***Speed of decision-making***

Leaving aside the 'returnees' who were in the main early adopters, only a minority of 'newcomers' became early adopters who went with the approach. They were less reliant on external validation or support and were capable of dealing with higher levels of uncertainty. The majority of 'undecideds' were potential '*early majority*' or '*late majority*' adopters. Diffusion theory (Rogers, 1995) suggests that the former group follow the lead of the early adopters but take some time before they decide to adopt a new idea; the latter are sceptical and cautious and will only adopt when the majority are already in favour and they are under pressure from peers. Essentially the 'undecideds' would only come off the fence if and when the innovation became more established in the social

system. For this group, the process of sense-making is less dependent on their own subjective assessment and more dependent on the assessment of others.

## **ENVIRONMENTAL FACTORS**

The work environment consists of both the macro -organisational and micro-organisational local context.

### ***The Macro-Organisational Context***<sup>301</sup>

The organisational backdrop for this training event had particular features as outlined in Chapter Two. For health boards, it was a time of immense change with conditions verging on (if not actually in) flux in some areas. Organisational priorities were shifting. In the light of the new organisational requirements (the building of a coherent child protection system) a system of service delivery which had appeared effective (being focused on responding locally to variable needs) now appeared fragmented and unfocused. What some had considered a strength of the organisation was now deemed to be a fault as structures and priorities were redrawn. Increasing political, social and legal scrutiny raised tension levels all around and resulted in the concrete introduction of new levels of management. Practitioners' positions, levels of autonomy and roles were being redefined.

Another organisational feature of significance was the low level at which health boards were functioning as '*learning organisations*' (Joyce & Kenefick, 1995) where the actual culture of the organisation was resistant to the examination of mental models. While this cannot be automatically generalisable to the social work groups operating within the health board (especially given their professional training which emphasises both supervision and reflection on practice as important processes) it must at the least have created some tension and dissonance for the social work groups involved.

The lack of any organisational emphasis on *continued professional development* certainly did not inspire employees with any aspiration towards lifelong learning. Made obvious by the absence of any training units or organisationally-led initiatives, this gap in itself both made evident and contributed to a culture which resisted innovation rather than welcomed it. This was in contrast to the culture in the adult and child psychiatry settings where the introduction of new approaches was a status-conferring activity.

The tensions that were evident in the health board setting, and the contrast between the conditions of flux perceived to exist there versus the conditions of stability perceived in other settings,

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<sup>301</sup> Analyses of the organisational contexts of those from outside the health boards is not considered due to the relatively small numbers attending from any one other agency and the total numbers of agencies involved.

combined with new employment opportunities, also contributed to another feature of the organisational context, and that was one of increasing mobility amongst the social work workforce. The respondents who moved in the 12- 18 month period prior to interview, all moved out of health board frontline positions either to more specialist posts or into management positions. This is a factor likely to have an impact in several ways – if it results in staff shortages, it puts pressure on remaining staff and so impacts on practitioners’ ability to have time and energy to devote to innovation; it may impact also on morale; and it may deprive a service of its more experienced practitioners, leaving newer recruits without informal mentors and guides. On the other hand, if it results in the movement into the social system of other practitioners and managers sympathetic to SFT, it could have a positive impact in regenerating interest in the innovation.

That all of these features would impact on participants was hypothesised in the literature review but findings are somewhat at variance, in that influences at the local level (cultural, structural and individual) interacted with the broader influences to create significant variants of context.

### ***The nature of the social work role***

That generic practice methods might be more easily applied in some settings than in others is often suggested in textbooks (Payne, 1997; Coulshed & Orme, 1998) but is somewhat contrary to the concept of generic practice theories being sources of ideas and vehicles for relevant skill development as found in empirical studies (DHSS, 1978; Fook *et al.*, 2000). What then is to be made of the findings from this study that show a differential level of ease of adoption and actual adoption not only across settings but, in the case of the Health Board, between different local areas?

SFT achieved highest usage and most positive ratings in terms of its ‘fit’ with social work in the fields of adult and child psychiatry and other therapeutic settings.<sup>302</sup> These successful adopters reported an effortless transfer of the innovation from training to practice. To some extent this is unsurprising, given the acceptability of ‘therapy’ in these settings where the innovation fitted in with social system ‘norms’ and increased the possibility of its adoption (Rogers, 1995). Furthermore, adoption of a therapeutic innovation by these practitioners was not only seen to be legitimate but also conferred some extra status on them, even if the therapeutic approaches favoured by others on their team were at variance to the innovation. Experimentation with new therapeutic approaches, it appears, was something to be rewarded in these multi-disciplinary settings.

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<sup>302</sup> Defined previously as those settings where workers did not hold front-line statutory responsibilities and where psychological change-work was seen as part of the social work task.

In contrast it was evident that for some of the workers from health board settings, the ‘therapy’ label was more problematic with ambivalence being voiced about ‘therapy’ generally, and several practitioners mentioning that they would not be calling themselves ‘brief therapists’ even though they viewed the approach positively. From findings in other studies<sup>303</sup>, and the researcher’s own experience of health board social work, it can be surmised that the discourse of social work in the community care health board setting historically distrusts the ‘therapy’ paradigm for a number of reasons<sup>304</sup>. In contrast to the psychiatric practitioners, adoption of the innovation for health board workers from some particular areas was likely to be in opposition to system norms although for a minority of others the opposite was the case. The significance of the influence of ‘near-peers’ and managers in the local social system (Rogers, 1995) is thus confirmed, but the presence of both single sustainers in health board settings and clusters of adopters and non-adopters in specific settings also indicate individual variations in levels of dependence on the opinions of others, and demonstrates the strength of the individual practitioner’s philosophy and orientation as a variable. Individual practitioners interpret their roles differently even within areas where clear system norms exist.

#### *Mono versus multi-disciplinary settings*

The existing literature on the impact of short courses in the post-qualifying context makes no reference to differences that exist between mono-disciplinary teams (such as health board or local authority social services) and multidisciplinary teams (such as child and adult psychiatry services) and the extent to which this may be a variable influencing outcomes. Yet the findings from this study show that different processes occurred in the social systems, related to the mono- or multidisciplinary nature of the setting. While the *nature* of the innovation clearly was an important component (in that it fitted best in settings where social workers saw a clear mandate for therapeutic work) there were also differences in the support systems and decision-making behaviours of practitioners on multidisciplinary teams compared to those on mono-disciplinary teams. Social workers on mono-disciplinary teams or multidisciplinary teams have different organisational and team cultures to contend with: in the case of the former they can be said to have both the advantages of the potential extra support available from social work colleagues if enthusiasm for experimentation with a new approach is shared, and the disadvantages of a more pervasive professional ideology to contend with if the general attitude is negative towards the innovation. In the case of the latter, there is the disadvantage of the lack of social work colleagues with whom to share experimentation but the advantage of greater individual autonomy in defining what is acceptable for a social worker to do. Single-handed social workers in voluntary and other

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<sup>303</sup> DHSS (1978) study showed how use of an ‘in-depth’ approach by a minority of practitioners was viewed with disapproval by the majority, who not only viewed it as ‘inappropriate’ for that setting but also voiced some ideological differences.

<sup>304</sup> These would include firstly the perception that, with a few notable exceptions, most of the contracted-out psychiatric services in the region operated as elitist services, and secondly that therapeutic interventions pathologised individuals for what were essentially structural inequalities.

settings also need to be more self-reliant in the absence of a peer network (unless they form alliances with non-social work colleagues). A sub-dimension of the work environment as a variable influencing the outcomes of innovation-diffusion is therefore that of the relative proximity or distance of near-peers of the same profession.

### ***The interaction of macro-organisational and micro-organisation (local) influences***

Some academics (Howe, 1992; Ferguson, 1994, 1995; Buckley *et al.*, 1997) argue that broad influences such as socio-political expectations, statutory mandates, and organisational policies and procedures are critically important in determining the shape of practice in the child protection/child welfare arena. Fook *et al.* (2000) examined differences in work *context*, between government (predominately child protection) and non-government settings, as a variable affecting the development of professional expertise. They found that workers in government settings appeared to lag behind their colleagues in non-government settings in terms of social work skill, values and knowledge development. The impact of the work setting was found to permeate not only the workers' own perceptions but also their overall orientation.<sup>305</sup> They concurred with theorists such as Howe in suggesting that this is due to the stressful nature of child protection work and the bureaucratic constraints of the work.

The findings from this study, from data gathered from a range of practitioners in different government (health board) areas and locations challenges a simplistic analysis based on macro-factors alone, as the evidence exists that there were distinct differences in culture and ethos between the area teams<sup>306</sup> and that micro-organisational factors came into play in the innovation-diffusion process.

### ***Micro-organisational influences***

From the organisational literature, Coghlan (1994) suggests that local team and inter-team level dynamics are of fundamental importance in how change is perceived in organisations and consequently processed, and the findings of this study lend support to this assertion. Furthermore, these findings suggest that team level factors can *mitigate* the impact of macro factors as outlined above.

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<sup>305</sup> '... workers in government settings found the context restrictive and therefore problematic. In contrast, those in non-government settings found the setting to be a creative resource and so were able to creatively utilise it and 'get around them' ... In non-government settings, workers tended to adopt a holistic orientation, in which they recognised that the contextual elements were integral to relevant practice in a situation ... Workers in government settings, in contrast, tended to be much more minimalist in their orientation as they were constrained by the statutory focus of their work; this meant that they were less contextual in their orientation to their work and clients' (Fook *et al.*, 2000: 173).

<sup>306</sup> The term 'area team' is used to denote the groupings of workers according to specific locations under at least one common social work manager, usually a senior social worker. While the structure was undergoing change at the time of the fieldwork with more team leaders being appointed to manage expanding teams within the areas the prevailing 'identity' was still thought to be with the 'area team' rather than the emerging sub-groups.

Leaving aside those from voluntary or non-statutory settings, participants in this study came from ten different health board community care areas (as well as two specialist services). Broadly speaking, two different *cultures* of practice could be discerned. One, in which respondents displayed a generally high level of anxiety about the nature of the social work task, were preoccupied with bombardment rates and a sense of crisis and overload, appeared to lack support from managers, and felt too demoralised or lacking in confidence to experiment with a new approach however positive they were about the innovation itself. The second was one in which practitioners appeared to be less anxious and even hopeful about the social work task; did not appear to be as concerned with managerial matters such as bombardment rates and waiting lists, and appeared to have both time and energy to move beyond a reactive form of casework to one in which they planned interventions and tried out different approaches (such as the innovation) in their work. The existence of area-based clusters of similar depictions of practice amongst the respondents strongly suggests differences in culture which are absorbed by practitioners as they become socialised into specific area teams. Whilst the dominance of a reactive, crisis-driven conceptualisation of practice where practitioners see themselves as victims of their work environment (virtually identical to Fook *et al.*'s description of Australian child protection workers) partially confirms this as a possible characterisation of child protection settings, the concurrent presence of clusters of more hopeful, creative and flexible workers in other child protection locations simultaneously challenges it as the *only* form of practice possible in such settings. Furthermore, it demonstrates that possibilities for creative work exist in such settings and that work settings need to be analysed in more depth and across local areas and teams in order to make sense of these differences. That these different cultures were also linked with either patterns of successful experimentation and adoption of the innovation, or limited experimentation followed by abandonment, further strengthens the argument that different cultures of practice exist which can either facilitate or discourage creative and innovative practice in statutory settings. What then are the team level factors of significance?

### ***The line manager – sacred cow or superfluous?***

Research studies until now assert that in social work, line managers (usually team leaders) have a significant influence on practitioners (DHSS, 1978; Crousaz, 1981) both as gatekeepers to referrals and 'appropriate work', and as guides to practitioners through the supervision process. In both the literature on the transfer process (Quinones, 1997; Reid & Barrington, 1994) and on the diffusion of innovation process (Smale, 1998) the manager's role is emphasised: 'The role of the line manager is critical. The manager or team leader can either endorse, support and enhance any new learning, or oppose, block and otherwise extinguish any new development' (Smale, 1998: 206-7).

But it has also been asserted that supervisors are not always the best supports for practitioners experimenting with new practices.<sup>307</sup>

For the Irish social workers in this study, line managers were not always present. Some practitioners, such as single-handed practitioners, those in voluntary organisations and some in multidisciplinary teams, were not working within structures which contained a line manager of the same profession. In these situations, practitioners appeared to become more self-reliant and autonomous and/or developed for themselves support groups and informal networks with which to support their practice. Several of the 'returnees' on the training course who were single-handed social workers in voluntary or multidisciplinary settings used the second short course in SFT almost as a form of supervision and support for their use of the approach. For practitioners in mono-disciplinary teams directed by a social work manager, variations existed in the role line managers either took, or were expected to take, in relation to the innovation. Some respondents referred to the views and/or levels of practical support and encouragement offered by line managers as a factor which, they felt had affected their experimentation and adoption of SFT, but others did not see this as a factor of relevance at all. The accounts of the latter group indicated that they enjoyed a relatively high level of autonomy in deciding how to work with particular cases, but whether this was a conscious decision by managers to *give* free rein to practitioners whose practice they had confidence in, or a conscious decision by confident practitioners to *retain* control of the way in which they carried out their work is unclear.

Compton and Galaway (1994) refer to the possibility that team leaders may not share the concerns and priorities of the practitioners they manage. Several practitioners alluded to a perceived lack of interest or even disapproval on the part of managers regarding their experimentation with SFT. Although this did not appear to totally stifle practitioners experimentation, it was perceived as a negative influence.

The accounts of managers themselves who attended the short course indicate that they also varied in relation to their interpretation of their role in the post-training environment. Some, who rejected the innovation as being of any potential benefit, understandably did nothing to promote its use but *neither did they actively discourage it*. Some liked the innovation but felt inadequate in trying to support practitioners implement an innovation which they themselves had not used in practice (or presumably come to own) but these managers similarly did not even voice their approval for the method to peers. One other manager thought that interest in an innovation should stem from the

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<sup>307</sup> Horwarth & Morrison (1999) have noted that 'Many supervisors, in our experience, say that they are unable to address the developmental needs of staff as they feel they are no longer experts and familiar with current developments in particular areas of practice. It is not so much the practice expertise of the supervisor, rather it is the supervisory skills that are crucial for creating and sustaining a climate for learning' (p. 158).

team itself and not be suggested, or imposed, by managers although he himself thought it could be of potential benefit. Several others who developed an enthusiasm for SFT took a more active role in either flagging up the innovation as a potential tool, or by more actively supporting and coaching supervisees in using the approach. The very active role taken by line managers in Area A combined with the high numbers of practitioners from this area who adopted the approach does lend support to the proposition that their influence can be critical but the findings from this study suggest that this is conditional.

Dynamics between practitioners and managers can vary enormously in that managers are not always looked to as role models or advisers on practice methods nor do managers themselves always feel comfortable or competent in this role. Where managers and practitioners do share an enthusiasm for an innovation and where the manager feels comfortable and confident in a directive coaching role, the synergy created can be a powerful reinforcing influence for the experimenting practitioner.

#### **THE PEER INFLUENCE PROCESS**

The nature of the information-exchange relationship between a pair of individuals determines the conditions under which a source will or will not transmit the innovation to the receiver, and the effect of the transfer. (Rogers, 1995: 18)

While the short course itself was an information-exchange event, innovation-diffusion theory would suggest that the heart of the innovation-decision process lies in the social networks and communication channels surrounding the individual. The findings from this study demonstrate how individual social workers firstly vary in their levels of reliance on the opinions of others, and secondly vary in *which* individuals in the system they consider arbiters of good practice.

The significance of the peer influence process varies depending on individual factors, (such as developmental stage and locus of control) and environmental factors (such as the availability of opinion leaders, and the types of communication channels in existence).

In relation to practice methods, those considered to be '*opinion leaders*' (Rogers, 1995) were not necessarily those with most formal power, i.e. senior managers or team leaders. They were also colleagues, or in some cases, fellow professionals from different settings.

The successful adopters in this study either did not need to rely on support and guidance, or they recruited peers into an innovation-supporting role. Many of the unsuccessful experimenters appeared to experiment in isolation and to either lack that support or be unable to recruit it. Individuals appear to vary in how much or how often they talk about their practice with colleagues,

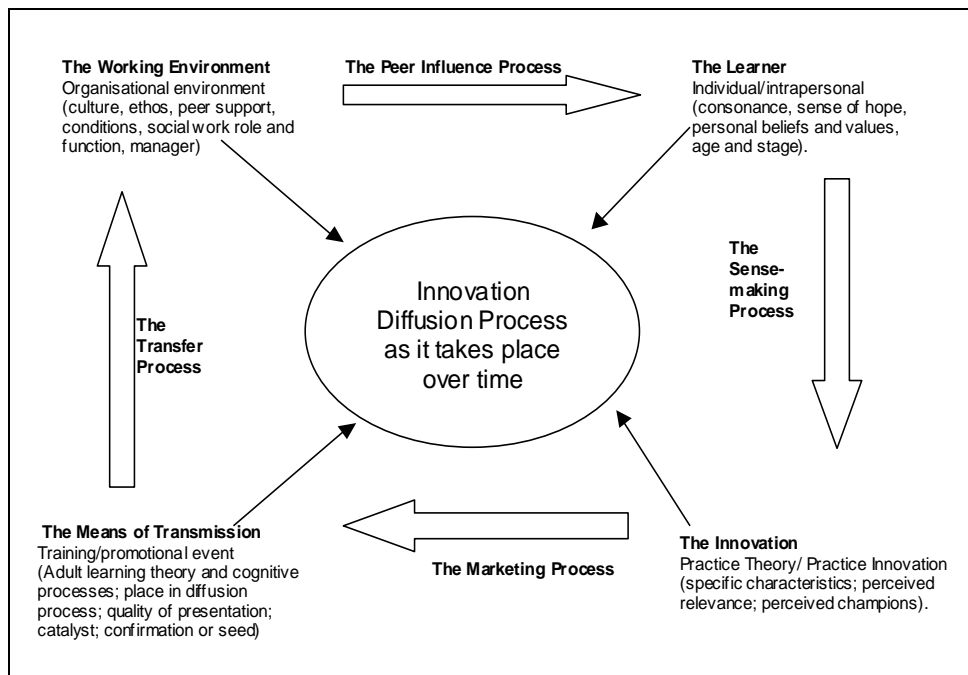


and further study could be conducted into this aspect of the working environment, and whether it *affects* innovation-diffusion and is also *affected by* innovation-introduction.

## CONCLUSION

Having reviewed the different components of the Innovation-Diffusion Process in Social Work, it now becomes more evident how complex the interaction of the different variables of the Innovation-Diffusion Process in social work is. The Chart mapping these components and the processes interlinking them is now reintroduced in some detail to more accurately reflect some of the sub-dimensions of the variables influencing the process.

Figure 9: The Optional Innovation- Diffusion Process in Social Work, components, processes and specific factors<sup>308</sup>.



<sup>308</sup> The innovation-decision process takes place over time. Time is a central component of Rogers' theory and its importance is signalled here through its inclusion at the heart of the process. As the data collected in this study only covers a 12-18 month period, further studies are needed which can map the time component for social work innovations more thoroughly.

## CHAPTER TWELVE: CONCLUSIONS

Professional knowledge cannot be characterised in a manner that is independent of how it is learned and how it is used. It is through looking at the contexts of its acquisition and its use that its essential nature is revealed. Although many areas of professional knowledge are dependent on some understanding of relevant public codified knowledge found in books and journals, professional knowledge is constructed through experience and its nature depends on the cumulative acquisition, selection and interpretation of that experience. (Eraut, 1994: 19-20)

### INTRODUCTION

Despite the inherent difficulties involved in investigating an ‘ideas-only’ *theoretical* innovation<sup>309</sup> and its transfer into social work *practice*, this study took up the challenge of researching such a phenomenon and process. Taking the form of a case study, it focused on a particular training initiative on SFT<sup>310</sup> triggered by a group of social workers in one organisation interested in diffusing a ‘new’ practice method to their peers and colleagues.

The study set out to address three main areas:

- How do social workers incorporate theoretical innovations into their practice in the post-qualifying context?
- What factors influence the processes of engagement with and evaluation of innovations in social work?
- What is the role of the short course in the process of innovation introduction, diffusion and evaluation?

### RATIONALE FOR THE STUDY REVIEWED

These research questions and aims were justified given the dearth of information in the social work and social care field about how new ideas are diffused in the social work field and specifically *how* the ‘training’ or short course process works (Clarke, 2001). Despite calls for ‘best practice’ to include evaluations conducted later than the ‘reaction’ stage and going beyond a simple assessment of whether training objectives have been achieved (Horwarth & Morrison, 1999, Clarke, 2001), this simply does not occur for the majority of training initiatives. The main reason for this is obvious. It is simply not practical or feasible to conduct in-depth studies into the plethora of short courses run

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<sup>309</sup> Rogers (1995) notes that ‘ideas-only’ innovations have rarely been studied by diffusion scholars. Methodological problems exist with such studies ‘in that their adoption cannot be easily traced or observed in the physical sense’ (p. 13). Yet, the matter of *how* ideas-only innovations are diffused amongst, and processed by, social workers is of some importance to practitioners, educators, training units, employers, and ultimately clients and users of social work services.

<sup>310</sup> The SFT innovation is essentially a particular approach to practice focused on one of the central tenets of social work – the ways in which practitioners relate to, engage with and attempt to work towards change with clients.

for staff in most social care agencies. But training initiatives and short courses (organisationally or practitioner-led, imposed or optional) need to be informed by greater awareness, firstly of the processes whereby theoretical innovations become translated (or not) into practice options, and secondly of the factors which influence workers' engagements with, and assessments of, new ideas.

Clarke (2001) reviewing studies carried out on the impact of in-service training within Social Services concluded that:

... [the] shift in emphasis...to studies which also seek to answer how or why training has worked, represents one of the most significant advances made within the field of training research ... Following increasing calls within the academic literature for a 'paradigm shift' from research which shows whether a certain training intervention works, to research which simultaneously focuses on issues of *why* training works, studies need to be undertaken which specifically incorporate variables posited to influence the transfer of training and examine their relationships with training outcomes. (Clarke, 2001: 769-70, my emphasis)

This study aimed to make a contribution towards answering some of the under-researched 'why' questions. Specifically:

What are the individual characteristics which influence the transfer process?

What factors in the work environment encourage or militate against the adoption of changed work practices?

How do social workers theorise their practice and draw on formal theory?

To do so necessitated an in-depth exploration of a short course and its function in the innovation diffusion process as it occurs in social work, analysing factors at the *macro organisational* level, the *micro-organisational* local team or 'micro-culture' level and the *individual* level. It required not only a description and exploration of the processes which occurred for workers as they moved from the short course back into work settings, but also an identification and analysis of factors, both individual and collective, which impinged on whether or not they took the ideas further and with what results. Practitioners and practices do not operate in a vacuum. As Howe (1991: 148) notes: 'We need to consider the relationship between a particular practice, the times in which it lives and dies and the context in which it does well'.

Added to this can be the insights gained both about the particular practice model of SFT, practitioners, and about the state of social work, from an analysis of the contexts within which it did not flourish. SFT gained a prominence in the Irish social work setting for particular reasons and so this case study expanded the analysis of a particular phenomenon to an examination of the local social networks and their impact on the innovation-adoption process, and an exploration of the processes whereby this practice innovation was introduced into the local Irish social work context.

But as in all real-life research, this investigation has its own particular strengths and weaknesses.

## EVALUATION OF THE STUDY

Fook (2000) suggests that researchers often start in the wrong place by focusing on research methods as opposed to the experiences one is trying to access.<sup>311</sup>

Given the high rate of interviews obtained from eligible respondents and the quality and quantity of data collected in the transcribed interviews, the study was successful in eliciting detailed data regarding the central research questions. It was also successful in eliciting narratives of the journeys followed by individual respondents from initial 'news' of the innovation, through routes to this specific short course and experiences of making sense of this innovation in relation to their practice. In so doing, the participants in this study have made available rich, thick descriptions both of their practice of social work and their ways of thinking about and theorising their practice. How they made sense of the innovation and how they built their own personalised theories of SFT were core processes in their narratives. Maintaining a focus on the desired end product of data collection, that of eliciting personalised accounts of using the innovation, required particular methodological decisions.

One critical methodological issue that arose early on was whether to track a smaller number of subjects over time or whether to survey a larger group of the training participants at one point in time. The option of selecting and tracking a prospective small cohort from the trainees offered the possibility of securing more rigorous data on the innovation-decision process as it would have been researched contemporaneously, but it also risked introducing more bias into the process. Practitioners who know they are being researched and are reminded of this through repeat interviews are likely to act differently than in naturally occurring situations. Repeatedly interviewing practitioners about a practice innovation was more likely to lead to a strong pro-innovation bias (Rogers, 1995) as it would inherently give the impression that innovation adoption was the preferred outcome. Alternatives to repeat interviews were also considered, such as journals and self-report questionnaires, but poor completion rates were feared for these. After much consideration, the second option of surveying the entire group after a period of time had elapsed was chosen because of two particular advantages offered. Firstly, it minimised interference in the naturally-occurring processes and secondly it maximised the possibility of gathering data on the contextual factors which influenced practitioners. This option did however include the significant methodological problem of reliance on participant recall. The critical factor in recall is that of salience – the extent to which the phenomenon remains prominent in the minds of the participants. It was a possibility that SFT and the short course would have had such a limited salience for respondents that recall would have been compromised. In fact the opposite was the case, and most

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<sup>311</sup> 'We should be asking, 'How do we access frontline practices in ways which will best enable us to theorise from it?' rather than 'What instruments allow us to collect best data on frontline practice for research purposes?' (p. 7).

respondents were able to remember accurately both details of the short course and SFT is a significant finding in itself. How reliable though is the recall of those interviewed?

Several features of the research design were created to act as checks and balances and to increase the internal validity of the study. Firstly, participant-observation at the course, collection of the course materials, and note-taking during the course enabled me to compare respondents' recollections with documents and my own observations. Secondly, increasing the numbers of respondents interviewed to a full survey of all still in practice a year later improved the validity of the findings as individual reports could be contrasted and compared with each other and patterns and clusters of phenomena identified. Thirdly, data on experimentation with the approach was strengthened by the request for case examples, which were supplied in most cases where participants had claimed behavioural change as a result of the training<sup>312</sup>. Fourthly, locating the study around one naturally-occurring training event facilitated the collection of data on environmental, training-related, and individual factors as well as providing a sample which contained clusters of workers from several locations. This allowed for the comparison and checking of participants' perceived environments as well as the collection of some harder data relating to local conditions and practices.

The adoption of innovation diffusion theory (Rogers, 1995; Smale, 1998) as a tool of analysis with which to interrogate the data was a critical decision in this research process. As a tool of analysis it facilitated an in-depth study of both individual and context, temporally and spatially. Educationalists and trainers in the British National Institute of Social Work had already found it to be a useful construct for managing change initiatives (Smale, 1998). Interest in it is now also emerging from American social work journals (Herie & Martin, 2002). In neither the UK nor USA as far as I am aware has its use extended to applying it as a tool of data analysis in empirical studies of social work. Rogers' theory initially appeared to offer the possibility of combining reported qualitative attitudinal and behavioural data with a more quantitative mapping of the research population through the innovation-decision process – the best of both worlds! Alas, it was not to be. After struggling for some time to code and categorise the respondents into one or other stage of Rogers' model, it became apparent that with the exception of those confident early adopters, or confident early rejecters, it was extremely difficult both for respondents to themselves assess and articulate the impact of an 'ideas-only' theoretical innovation on their practice, and also for me as researcher to definitively categorise impact and 'progress' through the adoption process. The only solution methodologically and theoretically was to abandon the search for unattainable certainties and highlight the provisionality and uncertainty still experienced by a large number of the

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<sup>312</sup> The use of case vignettes, where respondents would apply their knowledge of SFT in a hypothetical exercise, was considered, but as one of the main aims of the study was to access the sense-making processes which were followed, rather than establishing whether the innovation was being adopted in any normative way, the use of case examples was considered preferable.

respondents by creating the category of ‘undecided’. A further examination of the data relating to the ‘undecideds’ compared to that of the confirmed adopters and rejecters uncovered important environmental and individual variable differences and raised other relevant issues regarding the levels at which practitioners are challenged and practices reviewed through short course initiatives.

Diffusion research has been heavily criticised in the past (Rogers, 1995) for its ‘pro-innovation bias’<sup>313</sup>. Conscious of this danger, the decision was made to analyse equally those who did successfully adopt the innovation and those who did not. The identification of the changes triggered by the short course for some of the non-adopters raised the significant issue of whether there was as much of a difference between the adopters and non-adopters as categorisation suggested, and indicates that this is an area that requires further study.

It is hoped that the identification of incidents of re-invention, and the exploration of factors which prevented interested<sup>314</sup> respondents from experimenting or adopting the approach will make a contribution to the diffusion literature, in line with Rogers’ recommendation that

... it should be acknowledged that rejection, discontinuance, and re-invention frequently occur during the diffusion of an innovation, and that such behavior may be rational and appropriate from the individual’s point of view, if only the innovation scholar could adequately understand the individual’s perceptions of the innovation and of his or her situation, problems and needs. (Rogers, 1995: 108)

The adoption of Rogers’ theory was successful in enabling me to identify and incorporate non-training design variables which emerged as critical factors in this study in both the ‘before’ and ‘after’ training environments such as the significance of near-peers and the quality of communication channels between different actors in the social system.

The importance of the ‘marketing process’ of an innovation and the routes through which innovations are introduced into specific social systems is not an area covered by the traditional training literature, and gave added depth to the case study dimension of the research, providing a richer contextual dimension to the short course. ‘*Social marketing*’ is an area and process which warrants further research although there are indications that this is already underway in American social work (Herie & Martin, 2002). The concept of ‘*prior conditions*’ also proved very useful and

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<sup>313</sup> Rogers states that ‘The *pro-innovation bias* is the implication in diffusion research that an innovation should be diffused and adopted by all members of a social system, that it should be diffused more rapidly, and that the innovation should be neither re-invented nor rejected...The bias leads diffusion researchers to ignore the study of ignorance about innovations, to underemphasize the rejection or discontinuance of innovations, to overlook re-invention, and to fail to study anti-diffusion programs designed to prevent the diffusion of ‘bad’ innovations (like crack cocaine or cigarettes, for example)’ (1995: 100, original emphasis).

<sup>314</sup> Interested practitioners were those who hoped to draw on SFBT following the short course. No judgement is intended of those who did not develop enough interest to intend experimentation.

in particular the importance of felt needs/problems as a motivational factor for practitioners to examine and change existing practices.

The adoption of Roger's framework also enabled an examination of some of the 'why' questions outstanding from the literature review as outlined earlier. While Rogers' macro-level theory provided a set of general principles useful as a guide and analytical tool for this study, it was insufficient in depth to illuminate all the processes which this study has found to be involved in an optional innovation-diffusion process in social work. The supplementation of the innovation-diffusion analysis with theoretical perspectives from learning theory, organisational theory, sociology of social work theory, and professional expertise theory allowed for a mapping of the phenomenon which encompassed three different levels (macro, middle and micro) of factors and processes. One particular strength of this study may therefore be seen to lie in the synthesis of knowledge from different sources and theoretical perspectives which have served both as backdrop and focal knowledge for the findings. The development of a detailed map of practice innovation diffusion in the post-qualifying social work context progresses this synthesis further, and it is with interest that I await further testing of this conceptualisation.

#### **SFT AS A CONTEMPORARY PRACTICE THEORY**

SFT had a particular value as an example for research in that it is a characteristic 'post-modern' theory. It does not attempt to develop a causal and comprehensive explanation of human behaviour or political processes. It is not exclusive, and no significant barriers of prolonged training, accreditation, or group membership exist for those wishing to 'join the club'. It has a general appeal across many different aspects of the social care and education fields. The philosophy and values are general, rather than explicitly self-contained within one belief system. It rejects the notion of religious orthodoxy and incorporates a clear pragmatism in its philosophy.

It was developed through global networking and has been adopted and adapted in many parts of the world. The approach is marketed as a flexible set of principles and has proven to have great potential for unpacking, deconstructing and reinterpreting. Its originators and promoters actually encourage such an approach above that of uncritical or wholesale acceptance. It was developed through 'ecosystemic epistemology' (de Shazer, 1983) based on the generation of theory from research carried out on practice<sup>315</sup>. Its early evaluations were based on clients' own experiences and perceptions of change, emphasising the importance of individual perspective and challenging the notion that objective, externally evaluated, statistical outcomes are the only gold standard by which we should assess practices.

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<sup>315</sup> Through direct observation and reviews of videotapes of therapists both expert and novice (de Shazer, 1985).

SFT offers practitioners some clear, simple, therapeutic strategies which are easy to remember, seemingly easy to apply<sup>316</sup> and easy to adapt. These therapeutic ‘tricks’ (not a pejorative term!) were, for a lot of these practitioners, real nuggets of useful theory which they adopted easily. Maybe the long-established assertion that practitioners use little formal theory in their everyday practice needs to be revised and refined – perhaps the problem has been that too much of the formal theory traditionally taught has been long on academic rigour and logic but short on practical use.?

SFT also challenges traditional paradigms and organisational agendas in the helping professions focused on notions of diagnosis, cure and reform. The often-assumed authority of the professional practitioner is challenged and the legitimacy of the client’s perspective upheld through the practices of active questioning and acceptance of at most a partial expert position.

### **THE MESSAGE OF HOPE<sup>317</sup>**

Practitioners in this study welcomed the message of hope implicit in the SFT approach. Yet, many of them sank back into a less hopeful and more resigned attitude once time had elapsed. The ‘buzz’ from the short course was not sustained for many once back at work. For some it was a change, and a change which was a significant shift from their day-to-day thinking and practices. For others it was an affirmation of their own preferred orientation to practice. For all, SFT offered them some simple strategies which many of them felt able to try out after a short training course. Although the importance of hope is now being recognised in the research literature (McKeown *et al.*, 2001; Selgiman, 1998), for the practitioners in this study it was wisdom derived from practice.

The extent to which themes of hope and despair, disillusionment and belief emerged again and again from the data indicates that hope/hopelessness is a significant factor in the practice of social work. It also raises questions about the nature of social work itself. Is social work inherently depressing? Do practitioners and agencies in some subtle or obvious ways militate against the maintenance of hope and why? Is lack of hope perhaps a coping mechanism to alleviate against the dangers of unrealistic optimism and the potential burnout or meltdown imminent if outcomes do not match expectations? Or is it, as some theorists suggest (Tiger, 1999) more related to inherently depressing and disabling features of human life itself?<sup>318</sup> Is the lack of hope a form of learned

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<sup>316</sup> As Lipchik reminds us ‘Brief therapy requires as much subtlety, patience and sensitivity as any other good therapy’ (p. 39).

<sup>317</sup> ‘To hope is to believe that something positive, which does not presently apply to one’s life, could still materialize, and so we yearn for it. Although desire (or motivation) is an essential feature, hope is much more than this because it requires the belief in the possibility of a favourable outcome, which gives hope a cognitive aspect and distinguishes it from the concept of motivation, *per se*’ (Lazarus, 1999).

<sup>318</sup> Tiger (1999) suggests that hope is a central functional component of human action, and ‘It is possible necessary for a seemingly paradoxical reason, which is that reality itself can be so depressing or intimidating or fraught with plausible problems that action can be paralysed ... The core conclusion is that at least moderate optimism or hope is necessary to overcome the capacity of the enormous cortex to



helplessness on the parts of practitioners? Is it a system norm and essentially adaptive or do individual perceptions and levels of hope vary?

That hope and optimism are significant not only for clients but also for helpers is now strongly suggested (Snyder et al, 1999; Seligman, 1998). Snyder et al also suggest that the maintenance of hope may be especially difficult for helping professionals simply because, day-after-day, they see individuals with problems: ‘What this sampling misses, of course, are the numerous people without major problems or those who have problems and are dealing with them through their own resources’ (p. 192). This combined with a fundamental human bias to remember the negative rather than the positive is in the view of Snyder et al, the reason why helpers can become focused on the negatives, both in clients’ stories and in their own.

But hope and optimism do not come about from cognitive reframing alone; a sense of mastery and achievement are also important for helping professionals as well as clients, and this is where practice models are important.

#### **DO PRACTICE MODELS MATTER?**

Maluccio’s research (1979) into the disparity between clients and practitioners views of the helping process concludes with the suggestion that practitioners in general are more pessimistic than clients and tend more towards pathologising explanations than clients<sup>319</sup>. Maluccio signalled that he believed workers’ pessimism was at least partly influenced by formal study and theory when he exhorted social work educators to make changes and ‘to shift the focus from pathology to human resources, strengths and potentialities’ (p. 198); to look for ways of teaching people to create or build on resources in their own ecological context and to develop their competence in transacting with their environment.

The increasing presence of formal theories centred around concepts of resilience, strengths, positive attributes, coping and ‘thriving’ skills as well as solution focused therapy, can be viewed as a move in the right direction away from problem-dominated and towards solution-oriented practice.<sup>320</sup> Whether practitioners trained in more recent years on courses which adopt a strengths-

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generate endlessly discouraging predictions of the pitfalls of any action. Hope is cognition’s positive discipline’ (p. 617).

<sup>319</sup> ‘Most clients felt that they had received help and gave evidence to support their conviction that they were functioning adequately, that they were strong enough to cope with life challenges and that they had significant resources in themselves and in their environments. Workers, on the other hand, stressed the clients’ problems and weaknesses, highlighted their underlying conflicts, and raised doubts about their capacity to cope in future life situations’ (p. 182).

<sup>320</sup> A shift in emphasis does not equate with a rejection of all other practice methods and philosophies. The need for social work education to continue to highlight and embed teachings on social justice and on the structural and cultural elements of oppression has been rightly stressed (Fook *et al.*, 2000).

based perspective will be any more successful in establishing and retaining optimism and relaying hopefulness to clients is an intriguing question which future studies might illuminate.

But what is realistic to expect from any practice model given the literature on practitioners' limited use of formal theory, the importance of 'common factors' on therapeutic outcomes, and the very real difficulties that clients can face, both structural and emotional? Does it matter which practice model individual workers claim to follow?

I maintain from the findings of my study that it does matter, in two distinct ways. Firstly, practice models need to be compatible with the social work ethos, and promote an anti-oppressive form of practice that remains sensitive to individual need while not ignoring the wider context. Secondly, practitioners also need to retain hope that change is possible, and practise in a way which relays that hope to clients. This attitude is one thing but skilled practice also requires a map which offers a route. The map may be an amalgam of different forms of knowledge and practice theories. It may consist in the case of 'magpie' practitioners of a little bit of this and a little bit of that, but without a map, how does a practitioner model hope?

Practitioners need to feel skilled and competent in techniques and interventions or complete practice models that can help to bring about change. Not only do they need to feel skilled in them but they also need to *believe* in them. This is where practice models, perspectives and beliefs come in.

Snyder et al (1999) note that

'therapists' confidence in and mastery of a chosen method ultimately works by enhancing the client's belief in the potential for healing. Effective therapists model both agency and pathway thinking through their confidence in and mastery of the techniques they use' (p. 183).

The attitudes which helping professionals display towards their clients and the messages that they convey are a powerful component of the helping encounter. They can either confirm despair or offer hope. But part of that attitude is the extent to which the helper feels competent and confident. Practice tools and practice skills enable practitioners to develop a sense of competence.

SFT, as one practice model, provided practitioners with some simple therapeutic strategies and it also provided them with a practice model which at its heart believes that change is not only possible but inevitable. It is a powerful combination but its very simplicity risks demoralising those who struggle or fail to use it successfully. In that way it is a double-edged sword, with great potential but some dangers. That it could not cover all eventualities was evident to most of my respondents by the time of the research interviews but do proponents oversell it?

The dilemma for proponents is that, in order to counteract pathologising discourses, the strengths and resources that people can draw on (the forgotten reservoir of wisdom which Milton Erickson referred to) must be emphasised at great length. Coupled with the tendency inherited from the family therapy field to promote SFT through conferences focused on success stories, SFT might be in danger of losing potential adopters. If instead proponents can remain centred on the simple but effective strategies for promoting change which can be practised and adopted with relative ease, and combine this with a greater focus on building an anti-oppressive base, then it may have an enduring place in social work practice.

#### **CONSIDERING CHANGE – THE ROLE OF THE TRAINING COURSE**

Smale (1998) considers that social workers are notoriously bad at examining attitudes but the opposite was found to be the case in this study. The ‘old hands’ in social work, regardless of whether they adopted the techniques of SFT or not, found that they *had* to examine some of their own attitudes when confronted with a practice theory based on such different assumptions than traditional practice theories they had been taught.

Exposure to a new approach, especially one which challenges some of the established practices in social work while at the same time fitting in so neatly with the ethos which practitioners aspire to, not only required practitioners to examine existing attitudes and practices but also to make decisions. The decisions related firstly to the question of whether they would accept the innovation or not (to accept and try to incorporate it; to deny, dodge and reject it) and secondly, how to adopt or reinvent the innovation (to split principles from techniques? split techniques from principles? use selectively or universally?).

Individuals, dependent on the variables of developmental level, existing orientation, levels of ability, confidence and hope, perceived agency role and perceived agency conditions, will approach these questions differently. Environmental factors such as the agency function, organisational structure, local ethos and conditions, availability of support, and local attitudes towards the innovation will all impact on the individual’s progress, both influencing him or her prior to and following exposure to the new idea.

Planning and evaluation of training initiatives focused on the introduction of practice innovations must take in these complex interactions and in particular:

- The importance of individual perceptions particularly in relation to initial motivation to attend.
- The influence of the peer group, networks and relationships of influence which are contained within but also transcend agency boundaries.

- The significant range of roles which individuals in local (formal and informal) peer networks play in shaping collective perceptions and in determining standards and styles of good practices (including which innovations to follow), depending on their status within these networks.
- The role of line managers and the conditionality of their influence depending both on what they offer and how they are perceived.
- The differing social networks and peer influences present in mono- and multi-disciplinary settings and the relative levels of isolation, autonomy and self-sufficiency displayed by individual practitioners.
- The importance of the local area ethos, its direction and the extent to which it is implicit and unexamined or explicit and consciously shared.

The most important principle for ensuring that training and short courses do not lead to demoralisation but build practitioners' competence and confidence is to ensure that adoption remains optional and premised on the individual's own level of belief in the model, and that it is followed by opportunities to develop skills in the workplace with peer support.

#### **FORMAL THEORY AND THE CONSTRUCTION OF PERSONALISED KNOWLEDGE – IMPLICATIONS FOR INNOVATION-DIFFUSION**

That social work practitioners do not adopt practice theory in the standardised ways suggested by textbooks is by now an established research finding (DHSS, 1978; Curnock & Hardiker, 1979; Sinclair & Walker, 1985; Fook *et al.*, 2000) borne out by the results of this study. Instead social workers have been found to draw on particular concepts and ideas from formal theory, but *what* they adopt and *why* when faced with a practice innovation is a process that has been until now less well understood.

Practitioners interpret practice theories in a variety of ways and whilst there are strong similarities throughout a cohort of practitioners as to the aspects of an approach that will appeal, the findings from this study suggest that the experimentation that they conduct with new approaches (and on which, according to Eraut, 1994, their development of personalised knowledge will be based) in the early stages of an innovation's diffusion will in most cases remain within a form of practice sanctioned by their near-peers as conforming to system norms.

What individuals from a cohort of practitioners take, and how they use it, will depend on their reading of the approach and their felt needs at that time. For many working in teams this process will be influenced by the collective culture of practice and collective reading of the innovation. For those in isolated posts, the process of engagement with an innovation can be a struggle without peer support and feedback but those with a strong internal locus of control will weather this.

For a few, a serendipitous encounter with a practice scenario similar to a training one might trigger experimentation; for other more experienced confident workers, ideas or techniques will be ‘cherry-picked’ from the innovation and added to the practice toolkit but otherwise, established personalised knowledge will only be dislodged by a newer idea or intervention if the practitioner becomes ‘stuck’ and finds that the tried and tested interventions are not working.

New ideas and techniques only become embedded as personalised knowledge if they prove either through their philosophical appeal or through their tested qualities in practice to be congruent with the practitioner’s aims. What the practitioner might be aiming for in any practice scenario is not always articulated (and perhaps not always consciously ‘known’ by practitioners) but if the result fits, then it makes sense.

Innovation-diffusion in social work, when centred on ‘optional’ practice methods, will not conform to standardised expectations or neat patterns of wholesale adoption because it is an acceptable if not essential system norm for practitioners to draw on a range of ideas and techniques. Outside of specialist settings such as child and family psychiatry, where inter-disciplinary competitiveness, a ‘learning organisation’ culture and a teaching role are more likely to focus social work practitioners’ minds on demonstrating theoretical fluency and influence, social work practitioners do not appear to need to hold onto the formal theoretical roots of their personalised maps of practice.

Claiming allegiance to any one practice method in social work is a hazardous business and one which practitioners are only likely to claim publicly if they have something to gain from doing so.

Bearing out Rogers’ warning about the difficulties of researching ‘ideas –only’ innovations, the absorption of aspects of formal theory into an often unexplicated set of rules or ideas which guide practice, suggests that researching the innovation-diffusion process in social work would actually get more difficult as more time lapses between the introduction of the innovation and the research process.

### **THE COMPLEX ENVIRONMENT OF CONTEMPORARY SOCIAL WORK**

The field of contemporary social work practice in Ireland has changed dramatically even in the short number of years since this study commenced. Globalisation has added features in the form of international economic partners and employers, increasing international workforces, rising immigration, falling emigration and increasing economic wealth. Ireland has become a success story economically.

Social changes have also occurred at great speed. Increasing diversity is evident in the composition of the population which is now, at least in the main urban areas, reflecting a multiracial reality. Demographic patterns now also reflect increasing diversity in terms of family forms, patterns of marriage and cohabitation, living arrangements and relationship patterns. These changes have not been universally welcomed. Alongside positive developments such as the introduction of potent Equality legislation, increasing tensions and concerns exist regarding the rise in discrimination and racism against groups such as travellers and refugees. Ireland's levels of alcohol consumption, never a matter for national pride, have now soared and drug misuse remains a persistent problem. Rising suicide rates, a rapidly growing population of older people and increasing concern about the nation's children all contribute to a situation where social work expertise is simultaneously sought and questioned.

Social work services have expanded in many areas of practice. The larger organisations, such as health boards, now employ larger numbers of practitioners allocated to various specialisms. The nature of the tasks they are expected to achieve appear to become more complex and involve more and more knowledge acquisition and an ever - expanding practice repertoire. The increasing managerial component visible in both medical and child protection fields was highlighted in an earlier chapter. If anything it has become more evident and pervasive in the intervening years. Yet, as Fook *et al.* (2000) so rightly point out

Globalisation can be seen as responsible for greater unifying and a compressing of difference on the one hand, and on the other for a social fragmentation. There is a clear contrast between the managerial and regulatory practices existent in the organisations within which professionals practice, and the culture by which professionals and consumers know and understand their experience. How do we reconcile the two positions? (p.241)

*Whether* the two positions are reconcilable is another point worth considering especially when as Fook also points out, the domination of professionals by managers is also about unequal power relations and the privileging of one set of discourses over others. Howe (1986) exhorts social workers to accept organisational mandates:

It is no good their jeering from the sidelines. As an occupational group, social workers have to join in; they have to explore and understand the nature of their work from within its current confines rather than come along with a new set of rules and expect everyone else to stop playing the old game and try the new one. (p. 164)

So what should social work professionals do? Accept the new order and succumb quietly to organisational dictates and managerial control or consider more strategically ways in which to promote professional discourses both within organisations and within the wider social system?

Fragmentation of the social work profession in Ireland will continue apace if the professional group itself weakens and loses interest in core questions around social work values, and the conflicts and tensions that arise in different fields of practice when social work values and organisational functions clash.

Continuing professional development is one route to continuing reflection on, and promotion of, professional issues but only if practitioners retain some control over its focus and do not allow it to become either jettisoned by employers or organisations, or hijack to only meet their needs.

Short courses, conferences and such events can act as potent forces in enabling practitioners to retain some of the core concerns of social work and resist becoming unquestioning agency functionaries. Cross-agency, peer-led events can strengthen possibilities for networking and expanding and strengthening communication channels across the professional group. In these ways professional discourses can remain both strong and informed. It is not only in practitioners' interests but also in the interests of employers *and clients* that practitioners are facilitated in processes of reviewing existing practices, considering their attitudes and values, continuing to develop and articulate more explicitly their personalised theories, and retaining or rebuilding a sense of confidence, competence and hopefulness in the helping enterprise.

The pursuit of continuing professional development when coupled with an individual openness to innovation is in itself an exercise in living in hope, a hope that motivates and energises. If hope itself expires then individual and collective action falters.

Notwithstanding its perversions, hope is not only necessary for individual people in their various enterprises, it is also an essential vitamin for social process. If everybody awoke each day to announce 'It's hopeless' there would soon be no plausible tomorrow and no continuous social arrangements. (Tiger, 1999: 622)





## **APPENDICES**

### **APPENDIX A – TRAINING COURSE NOTES (IVESON, 1995)**



























## **APPENDIX B: RESEARCH INTERVIEW SCHEDULE**









## APPENDIX C – RESPONDENTS’ DESCRIPTIONS OF SFT IN SUMMARISED FORM

1. facilitating client to get creative about their own solutions
2. emphasises positives; empower client to come up with solutions; respect.; anti-elitism
3. approach 'nice, light, bubbly'; 'focus on positive attributes; looking always for exceptions
4. brief; a very positive way in which profs. can help; a diff. way of looking at things
5. clients as authors of own destiny; belief people can change; hopefulness; heartening and practical
6. ideas - v. good; positive emphasis; looking at things positively rather than looking for problems
7. very hopeful; 'that change could come with this particular intervention'; diff in approaching things
8. brief appeal for intake work; couldn't remember much else!
9. 'optimism'; 'enhancing the client's own abilities; see people in broader sense; gives a broader vision
10. 'so positive; it focuses on the positive and it's there to empower
11. 'a very positive approach to work'; very much appreciating the person and not just the problem
12. 'a more positive way of working'; belief that things could move and ... could mean positive results
13. it's empowering ... it really does empower the client
14. help client work towards a solution ... not impose your ideas; brief; adaptable- take pieces out and use
15. did NOT really take to approach - sounded too good and worked too well for him'
16. simplicity; very positive focus; 'it gave ... hope intractable problems could be turned around
17. you see the client and a possible solution; more optimistic for the worker that way as well'
18. look for positives; wasn't intrusive; use on its own or as part of something else; non-judgemental
19. a very positive theory; focus on people's strengths not weaknesses; gives hope and encouragement
20. focused approach - start exactly where the client is; really nice way of working
21. a different way of working that seemed to work
22. diff. -involve client more; look at where they are and get them to look at it a bit more positively
23. 'getting the client to do the work ... to look at what's happening in their lives + you help them to do it
24. different point of view; new approach - positives to be engendered - techniques to try and do that
25. different to what I was used to - focus on positives; on what's going right
26. so positive; appropriate; much more positive & affirming - almost total opposite of way we work
27. brief; personal resources of client-focused; practical and with specific techniques

28. refreshing (for worker) totally different way of approaching problems; concentrate on positives
29. mixed feelings 'too good to be true and nothing really works ... just in the door and I'm a pessimist'
30. client's responsibility for change (self-determination); frees up worker; structured and clear
31. more positive regard of people's abilities to solve their own problems - challenged assumptions
32. inclusive - clients come up with agenda; future focused
33. giving people back power and making them believe in themselves; positive focus
34. challenging idea that long term involvement required; imp. of questions, reframing and positives
35. time-limit; positive orientation; a possibility for change; clients identify clear goals
36. focus on here -and-now; client's perception is important; positives; focused
37. positives; pragmatic; active role for therapist; strengths and resources
38. hope for the worker - that they could actually do something; positive and hopeful for client also
39. responsibility for change lies with client; gives hope to the person & worker
40. positive - people can find their own solutions; conscious attention to how you work with clients
41. a new way of empowering people; build up strength & confidence; practical & accessible
42. focus on client finding own solution; better for client & worker; techs. help keep track of change
43. getting the client to see the solution and that they can reach it - steps; focused; practical
44. vague description - didn't really remember much- refreshing cause it had a diff. perspective
45. pos.; looks at ability to cope; element of hope; different & new; clients part in own treatment
46. No relevance or appeal but liked focus on goals, brief & breaking down global problems
47. helping clients to visualise their solution to the problem; strengths of clients in context
48. miracle q can free people up to move; less focus on past history; focuses clients & workers
49. solution focused; brief; clients own goals and solutions
50. not too impressed/mixed feelings -thought it 'slick'& simplistic but also empowering & focused
51. play on strengths; brief; client defines the problem & solution;
52. reframing of issues; encouragement to carry on; assumption that clients have answers themselves.

## APPENDIX D: CASE EXAMPLES OF USING SFT

### 1: partial use in a voluntary counselling setting

In this case the practitioner initially applied it to a piece of marital work in a private counselling setting:

*'I was working with someone who had a relationship difficulty and whose partner wanted to separate and she didn't ... she just seemed very stuck about what was the right thing to do, basically. Stuck in all sorts of ways, kind of a complicated thing ... I remember saying to her, if you went to sleep one night and wave a magic wand and wake up the next day, what would the scenario be? That seemed to be actually very helpful for her in order to reassess the whole situation.*

***And do you think it moved her on?***

*Yes, it did, actually it did.*

***And can you remember what the outcome of the case was?***

*Well, the outcome was that she moved on to accepting the fact that even though she wanted to stay in the relationship, her husband didn't, and just an acceptance on her part that the relationship was dead and that she had to move on from there really.'*

### 2: A fostering worker who decided that the innovation was not an innovation but an extension of good practice principles

*'It was kind of wearing and relentless for foster parents to be waking up to the smell of urine every day and the relentless changing of sheets and all of that kind of thing ... they were a bit worn down by that, anything we had tried hadn't worked, and this (SFT) didn't clear it either so I can't claim that' (my emphasis).*

The aspects of the approach which she utilised:

*what I tried to do was to ask her how she could handle the situation, how she could deal [with it] rather than going ape every morning which obviously wasn't going to help at all ... So I specifically remember coming up with that ... and trying to come at it from this (SFT) approach ... she would think that all those questions were a bit strange but she would humour me ... in fact, the problem in the last few months or so has eased'.*

### 3: Running into difficulties in medical settings

In one case the client was a long-term patient with rheumatoid arthritis who deteriorated suddenly:

*she became terribly anxious and then became terribly paranoid and it was very difficult to get her to focus on anything positive, so I did try it on her ... just by focusing on the good things that had happened and taking a day and talking about the miracle and those sort of things ... It worked to a point but then it didn't. But I don't think anything else would have worked either at the time because she needed medication ... and as it happened the medication was changed and she did make an improvement ... Just at that particular time she was so anxious, nothing was working'.*

The second medical social worker used it briefly with one person whom she was already seeing for long-term counselling, related to difficulties in the past which were affecting present functioning.

Although she had found the client difficult to engage using the SFT approach, she herself felt that the search for positives in itself had been useful. This work consisted of two sessions, following which contact ended because the client became an inpatient at another hospital and stopped attending this respondent. As the client did not resume contact following the two sessions, the worker was left in the difficult position of not knowing whether the approach had been useful to the client or not raising again the issue of observability.

#### **4: A residential child care manager who used 'elements' of it with one child just after the training**

*'the child would have been very, very angry, very very closed, very aggressive, and it was to try and deal with that in a more positive way ... so even though normally I would feel that we don't usually take a very behavioural approach, for this child we felt that anything on a relationship basis wasn't working with him. We tried to deal with him in a very sort of narrow behavioural sense - that there were consequences for any aggression or whatever ... [the SFT] was part of a way of trying to look at what we were doing with him or getting him to reflect on how his day had been ... and we are not talking about the same child at all, this time, this year ... I would put it down really ... he knew that there were going to be consequences for every single episode of violence and very very clear boundaries but at the same time the brief therapy element may have helped in the fact that there was still something positive there for him'*

#### **5: A child protection worker who tried it once and ran into difficulties of implementation**

*'A couple with three children but one of the children was being extremely difficult. They were having a lot of difficulties with him...hadn't been able to manage him from a very early age ... and basically were asking the health board to take him into care because they couldn't cope ... I suppose the father would have had a more negative attitude towards the child than the mother...We really didn't have places for the child anyway, and obviously I was trying to keep the child within the family ... I was visiting twice or three times a week and within these visits I was trying to get them to focus more on his positive behaviour ... to look a little bit more at what he has done and scaling questions ... if they mentioned that he had done one thing I would pick up on that. It was very difficult though and I found it worked a lot ... it worked more with the mother but the father already had developed this very negative rejecting attitude ... [also used questions] about coping. If you say that he has been this difficult for the last ten years how have you managed to cope? ... it's very sad ... The outcome of the case is that the child actually did come into care'.*

#### **6: A child protection worker who became a confirmed adopter**

*'A female client of mine who has children in care ... her partner has been violent in the past and has posed a real risk to the children. The children are on a care order ... He was still living with her and even though the children are in care they are a very close and loyal family ... I was trying to encourage and support her to look at how different things would be if she got a barring order ... at first, she was pretty afraid. She doesn't want to be alone and she was afraid of losing him. And then we started to focus more on the positive side ... the ripple effect, the effect on her children, the effects on her. It did take a lot of work and a lot of encouraging her and a lot of contact with her and a lot of support ... She always saw herself as being very passive and very vulnerable. And she got the barring order eventually ... for the moment things are very positive, things have changed*

*and it has had an effect on the children, cause they now see their mother as being safer, more secure and they see her as stronger.'*

### **7: A child protection worker who had doubts about the approach but had a case exactly like one of the video examples**

Her account of this trial is now given as an exception to the general pattern of experimentation (which was to use it when stuck as a last resort in a creative heuristic search.

*'A mother came in with her son and he must have been about 12, and she was saying: 'take him. I want to have him put in care'. And I said: 'Right. OK. And now you need to tell us the story. And he sat there and wouldn't say anything, and I tried to include him ... he just refused to speak. Mother was saying that was fine, too, whatever you want to do and so he just listened to his Mum and fairly soon in the interview I asked her to scale where she was and how bad she felt things were, and I think she put him on a 5, which was amazing. So, I did shock, horror: 'Wow, 5 is very high when you think about it'. And we used the whole thing then, through when things weren't so bad, and then you could see him actually – his body language, leaning over more towards his Mum. Then we asked the Miracle Question and she gave us a fairly run-of-the-mill day which seemed quite possible. And then suddenly he blew up and said: 'You don't know. You don't know. You don't understand'. And he stormed out of the room, and we let him...And then when he went out, his Mum said that she was worried. She had separated from her husband and had started seeing another man, and she was worried to tell him about this other man and it was obvious that the child knew, she felt he didn't. And so she disclosed this and she was worried about how she could do this. She felt that she was doing it wrong. And she didn't want to really lose him. Like he had been like her partner, I suppose. Amazing. He walked back into the room, just came in of his own accord, sat down and I asked him would he like to talk at all now....'No', he said, 'you just don't understand', and he went on again, and I just felt I thought he knew why. I just asked his mother for permission to talk about what she had said and her worries around what she had said. And she said 'allright' and I said it. And he said 'she thought I didn't know'. So it just brought the whole thing out and ... that all came out and he cried. And then I asked him if the miracle happened to him, how would he see. They were very similar days that he described, and so we just drew the similarities out of that and talked about when things were good how that felt. And she suddenly (the mother) stroked his ear. These people ... their body language completely changed. He was looking down, shy and listening, and when he heard that she worried about how to tell him, what to say, and that he was important and all the rest. At the end of the day, task for the end, was that they would have time set aside within the next week to do something special. And the mother came up with: 'do you want to do your confirmation day, or your communion day again?'. And that had obviously been a very lovely day for him and he smiled. And they walked out of the office. And I was absolutely drained (laughing). But it was just exactly how the video had been, and everybody got very excited in the office when I went and told them. And they didn't turn up again'.*

After a two hour interview, the situation had changed to one where mother and son were openly and emotionally communicating and went away positive about their relationship and no question of the child coming into care. The worker described the effect on her thus:

*'And I was absolutely drained. But it was just exactly how the video had been and everyone got very excited in the office when I went and told them, and they [the clients] didn't turn up again ... This was a woman who was actually wanting to leave the child - she was coming to drop him off and we were to deal with him. And they left ... It was very exciting.'*

## 8: An experienced child protection worker who implemented it successfully

*'I had a kid who was in major trouble in school and she was at risk of being expelled from national school ... she was 11. She had a chronic history of abuse in terms of extra-familial and placement problems but school was one of the issues [and] if she hadn't got a school placement, her foster placement was likely to break down'. The worker then described how she had carried out both direct individual work with the child herself and also involved the school by getting the teacher to look for positive changes ... 'so it was a dual thing. But it worked. It did work great. It worked for a while (laughs).'*

The direct work with the child started thus:

*'I generally said to her that one of the problems she had was school and that they'd been on to me and her foster mother had been on to me about it and I asked her if she could do anything that would make it different or would she like school to be different? And she said she would, so then we started on what happened in the school day, and we did the miracle question, and what the day would be like with that and then I asked her about exceptions ... one particular class. Usually the one she had that went alright was English and basically I got her to (I'm mean it's exhausting doing it) in detail tell me what the teacher said, what she said, what she didn't say and all that, and then we talked about trying it for another class and she did. So basically what happened was that I gave her a little checklist of things that she needed to do ... her goal was not to be in trouble in school. So she could come home and when her foster parents asked her how she'd got on in school, she could say: fine. How she'd feel about that, how she thought the foster parents would feel, how she would know if the foster parents were pleased, how that would make her feel.'*

This first session lasted about a hour and a half and the second session was also long because

*'I wanted to hear how things had gone in detail and we looked for more exceptions and then, it was generally a case of checking up with her when I'd been on to the foster mother anyway...also checks in with the teacher.'*

Following the SFT intervention it appears that the practitioner reverted to a monitoring position, checking with foster family and school on the situation. The worker saw this as a successful piece of work which she described as having knock-on effects for other things in the child's life as well:

*'in that she wasn't refusing to go to school, in that the foster mother was much happier with her, that the foster mother wasn't getting a lot of hassle from the school, and it just turned around a lot of the negative things that had been connected with this child ... it did turn around a lot of the negative attitude towards her. Definitely.'*

In this particular case, the worker's ability to hold onto hope and a belief in the child's competence was obvious as she described how events unfolded subsequently for this child in care:

*'Three months later, she was disclosing sexual abuse by her ... natural brother ... It was a relative foster placement and she just took to running away constantly, and went to various different placements and eventually came out with the abuse ... (and is now going to a residential placement)...I still refer back to it [her success with the school problems] – you know the way when things are a bit up in the air and she doesn't want to go to*

*school and I say: 'look, how much you changed when you were in X', and she does see that...I think it has left her with some sort of belief that she has some power – definitely. It is power in a positive way not a negative way.'*

## **8: Two child protection workers working together in community care who managed to successfully incorporate aspects into their practice**

The case was that of a teenage boy who had sexually abused a younger sister and a neighbour's child, was experiencing a lot of rejection within the family home and was perceived by the workers involved to be at risk of being ousted from the family home completely. One described it as

*'a fairly difficult and complex child protection case';*

the other described how 'stuck' they felt regarding models to use:

*'we were really at a loss ... will we try and work with this or will we not? I suppose just trying to find some focused way that we could begin – just to help Mum begin to see if there was any improvement'.*

In addition to the male worker seeing the teenager regularly, it was decided to offer joint work to the mother and son together on a fortnightly appointment basis. There was a total of seven sessions in total over a three month period. The specific aspects used were: scaling, identifying exceptions and amplifying them; the Miracle Question and goal setting.

*'We initially met with herself and we would have asked her to picture the Miracle day and she was able to relate to that but it seemed so far out of her grasp at that stage, so then ... it was useful to say: 'what will you settle for?' And what struck us was that what she was expecting was very realistic ... so then we met with him and Mum and got her to say very clearly what she was expecting and what she would settle for ... slowly we got the son to say what his expectations were and the starting point seemed to be a little bit closer than you would have imagined ... we had put in certain expectations before we met, of our own (things about him not being left in the house on his own with the younger children) ... over a number of months certainly there were ups and downs, but the actual giving the number actually helped us gauge as well. There was the scaling, and there was movement on the scaling ...'*

Both workers viewed this piece of work as successful in that the relationship between mother and son improved; his social and communication skills also improved during this time (this could also have been attributable to the individual work) and he was enabled to remain living in the family home and attending the same school for a period although he then left home at age 17 in a planned way and without experiencing outright rejection. Both were also cautious about what claims could be made in relation to 'observability' of the impact of the innovation, and also in relation to the extent of the changes:



*'I better be clear in saying that this was a piece of work that was done in the context of significant responsibilities of this department in relation to the family ... around this family we also had a consultant psychiatrist seeing the young child, I was doing individual work with the youngster, the Guards would have been backing them into the wall. There would have been a lot of other concerns and a lot of other people working around this family...but it certainly helped to reduce that [the rejection and battles between the mother and son] at the time. ... It [SFT] wasn't a God to solve this case, it wasn't a grand theory ... or a grand practice that was going to lift them out of it. But in relation to the specific piece, of how these people were living, it was helpful in that area.'*

**10: An experienced child protection workers who had definite 'stuck' cases in mind which he tried out SFT with.**

***OK, so can you tell me how you did use it then? Maybe if you could give me an example, that would be great.***

*Mum and Dad and about four kids, in their early to late adolescence, all secondary school going, except the youngest girl who was at primary school. Mum and Dad were very reluctant to involve services initially ... the referral was for a teenager boy who was not doing homework, acting out at school, truanting at school and suchlike. Very classical sort of referral. So, I got involved and basically I had been trying everything, individual work, looking at the relationships, looking at the family stuff, referring to the Mater Child Guidance, referring to Claid Mor, etc. etc. So they had been through a lot and nothing was changing - literally nothing. And I thought also that part of that was to do with the focus of the whole issue. Most of the agencies that were going in the focus was on the particular child as well, and his particular problem, so in a sense it was all problem focused. And I had been even trying to move away from that but hadn't done anything within the context of a structure. So I decided I'd try this out anyway - it seemed to me that it might be something that might work, you know. And I went this particular day, I had about two sessions and after the second session, this couple had not slept together or talked together for ten years maybe, literally. They had talked very much on a very polite level, you know, doing very little things. By building in a sense on all the positives in terms of - it came down to even looking at simple things like what they did for one another, is it like pouring the tea, you know? And that was the most positive thing that happened in their lives, you know. So a complete and dramatic change after two sessions. Firstly, they were going out nearly every few nights of the week - to the pictures together and for a meal. The meal for them would be a local cafe thing because they were unemployed, but this was occurring which was a dramatic change for them. They spent three hours - after the second session, they came back the following day, or something - maybe a day later, and they had spent three hours on one evening, just chatting about themselves and the past and how they get on and stuff, you know. So, obviously their relationship had taken a dramatic turn for the better. I was very surprised by that, and taken aback but em, it's a very good thing that's happening, you know. And one of the other things that I had said to them was to talk to each other about boundaries between them and the children. And we talked about, particularly if they were going to spend time with themselves, they needed to say: look this is our space now. Whereas in the past, they would interrupt and stuff, you know. So to make sure that that was part of their rules and that the kids can't get in there - that they chat to themselves and make time for themselves, etc, etc, you know. So, to me that was really very dramatic, and that continued, for months and months.... They were still getting on and talking and stuff. In fact, the boy then, his problems in school just dissolved literally, and it seemed to the parents - they were using terms, like he just grew up overnight, you know the way. And that part was obviously to do with the fact that, you know, they had decided that they didn't want to talk about him any more, you know? I don't want to hear about him, I don't want to see him - well, not totally, but that was the message they were getting from me, and I just wanted to talk about actually where they were at and also use - I mean, he would come up in discussions, obviously, you know and*

*how they were developing the positives aspects of their relationship with him, and I would just leave totally out talk about any of the negative aspects altogether. And I suppose, from there, I mean ,there was literally only a few sessions, you know.*

***How many sessions did you do altogether?***

*With specifically using the, the actual techniques - I would say about three sessions.*

***And what - did you stop see them then or what happened?***

*I saw them on a few occasions afterwards, a very few occasions - I was just dropping in to -in a sense I was planning to close the case anyway. I just said I'd give it a few months before just closing it and see how the young fella is getting on, and how the family are developing. So overall, he was actually - he improved quite a lot the young lad, and he was even saying - he was making statements like - this is probably separate again - he would make statements, like you know: there was a monster in me and he's gone at this stage. And he would have some insight into himself, you know.*

***And what age was he?***

*He was about 15 or 16 at that stage.*

***Right ... and so you had the three sessions and that, and then you continued to drop in and monitor?***

*Yeah, that would have been after - very soon after the sessions with Chris Iverson (sic) that I was in touch with that particular family.*

***And did you close it?***

*Yeah, it's definitely closed, yeah...And I've had no referrals so far (laughs). I've heard nothing yet.*

***Right. That's tremendous. And can you tell me just in the session, what were you doing?***

*Well, basically what - I would really start with the premise that - I would have said it openly and quite explicitly that I was going to try something different -literally. And, em I tend to be sort of - my approach would tend to be sort of that way anyway - to be honest and open about where I'm at, you know. And show them what I'm recording - if I'm recording, and stuff like that, you know. For those sessions, I didn't record anything anyway ... it seemed things were self-directed to an extent. What I tended to do was begin to look at - first of all the premise was: we are not going to actually talk about the problems at all, or any of the problems that are in the marriage or the family or the situation. What I want to talk about is what is and what has been working for you ... and what you've both being doing right. Em. So that took a lot of questioning and continuous questioning to find out exactly - there was some point along the line where we found something positive, you know. And that was continually doing the question bit. And, then at some stage, I would have used the miracle thing as well, with both of them there most of the time throughout the session. The Mum would have left the session the odd time to go and make a cup of tea for ourselves, and would leave and come back. Because it was fairly new, the way it was being discussed, so and then he [the male parent] would leave and come back but he mostly stayed. I'd say the whole session was about 2 hours max. - it was a pretty long session in that sense - and it was pretty tiring too. It seemed to be - I was using a lot of energy in terms of maintaining them on a positive thought ... very hard work. Because I found that they wanted to go back and talk at the problems every second breath. At the beginning, throughout the first hour, we'd then revert back to: but she did this and he did this - you know. And things aren't working in this direction. And it was like very hard work just to get them back on the track, yeah. But, so it developed like that, and we discussed their sense of - if everything was going right tomorrow, etc. etc. Perfect for you - what sort of day it would be, etc. Going through the whole thing of being totally specific, and this is where I feel the actual difference lies, is being, having sort of positive thinking about your future and what you sort of want to be you know and em, because it is so specific in terms of them detailing every ., even what the dog might be doing differently on*

*the day, you know. But detailing it as much as possible: how they might feel, what they might be thinking, or what people might be doing around them. To my mind they were actually constructing the day, where they were nearly living it already by actually talking about it*

***So, in that sense you were getting them as they were doing it to ...?***

*Yeah, yeah and I was pushing that, and as I sensed it developing I was going with them with it, you know that way and ... it was an avalanche effect the other way. But it was more in a sense of constructing it with them - you know the way? But not actually taking on the control sort of saying; what if this, em. Not leading them basically. But developing it with them.*

***And what were their miracles?***

*Well, basically their miracles were things like,em: Mum would say I would get up in the morning and I would have carpets on the floor, and in fact they had no carpets upstairs on the floors, or on the landing - in fact they no furniture upstairs at all except for one press between - one sort of clothes press between the whole family which is amazing. Em, so her wish was to get up in the morning for example - a miracle day, and be sleeping with the husband, come down stairs*

***They were actually sleeping separately?***

*Yeah, em and come downstairs and at that stage maybe get dressed, with sort of clothes that she'd like to put on rather than the stuff she had on. It was very, very specific. I mean, minute by minute she had it worked out and he had it too. And maybe he might get up and bring her breakfast in bed, you know. And that they would go for a walk together, that they'd go together to meet the kids from school. The kids would say this to them and they would say that to the kids, and the homework would be done in time and they would share some of that, they would discuss what the programmes on the TV were going to be in terms of ... you know, who wants to watch what ... it was very, very detailed. It was not: I want to win the Lotto, it wasn't anything exuberant.*

***Little everyday things?***

*Very much little everyday things, getting cups of tea, to sort of feeling really respected and loved, from whoever it was coming from. And it was like the exact approach, or the type of approach being used by solution focused gets to the kernel quicker, you know from their point of view. Because they are actually doing the developing and the thinking rather than me. I am pushing them, I know where I want to get them to go to, you know, but it must be from them and it comes from them, you know. And I think that's why it might work, if it works long term, you know. And I certainly - you couldn't say that because it worked for those few months and the case was closed and the kid seemed to be fine, that it works, you know. Obviously the long term research into those is needed. But I mean they were very clear about where they were going and what they wanted and what that miracle day was going to be like, you know. But that was real hard work to get them to that stage, you know. And I would say that the two sessions, I think it was maximum two sessions specifically using that, would have been four hours in total, I would say, you know.*

***And can you tell me did you try to follow the set session format, or did you more or less adapt it to the fact that you had already a way of working with them?***

*Yeah, I more or less adapted it because, at some level I said, I'm going to change the approach and we are definitely not going to talk about the ...??(changeover of tape) ... and they were very keen, and part of it was that they were motivated and that was the key thing as well. The key thing, like going to a family therapy session as well, like you know. But, yeah, I think that at some level they needed to have some motivation initially.*

***But staying on the positives, you say that you found that took a lot of energy?***

*Yeah.*

**How did you do that - what kind of questions did you ask?**

*Em, basically I would start off by saying things, like em, can you remember them - take them back sort of to the past first of all. The most recent event for example when they did something nice. Say I was talking to the husband, the most recent time that she may have done something that you found - in terms of, em, making the tea or. give lots of examples or throw in lots of examples, you know? And he would say: oh, it's been a long time now, you know? (laughs) or put it off or say something else, so in a sense I needed to say: hold on, go back again, just try and just think about it, I just need you to actually get to one stage about when something positive occurred. And he would go back and say: well you know, we did go for a walk maybe four months ago and maybe for ten minutes, and that was pretty nice, you know. So, then taking that from there, and doing the same with her and taking them back through the present and giving it some sort of: yeah if we did it before we can do it again, we can create the future for us that is better, make it our own. Taking control of their own future in a sense rather than it just happens. I think I was trying to give them that sense that they had this control. That wasn't in anybody else's hand even though they had debts... they kept coming back to the fact that if they had money, everything would become resolved, you know. But eventually they disagreed with that themselves, you know.*

**And then you were using the miracle question just to get a sense of how things could be different ... they were constructing the day ... so, what else were you using, scaling? or?**

*Well I would use scaling, in the sense, not very often. I felt it a bit artificial in a sense. Basically with the scaling it just seems artificial, for them to relate to that. And I would say: I would throw in and use it: I'd say things like: if I was to say on a scale of 1 to 10 and what I mean by that is? And I'd say: lets say that your experience was the worst thing you ever had, give me that and then give me the best thing ... so I'd use it to give - if we look at that experience; do you think that was in the middle of the scale? ... a sense of that ... yeah it was good to use scaling in that way, yeah, but not specifically 1 to 10, you know.*

**And then did you give them any kind of formalised feedback or any task at the end of the session?**

*Yeah. The tasks were quite clear, yeah. We actually had written up lessons of what they had to do together - and separately as well. I think they actually did achieve those things as well, you know. One of the was that they would actually sit down and spend some time for themselves and create boundaries ... and another was about the television time for the kids - the fact that the kids used to come in and sit there and the parents weren't allowed to watch anything ... (laugh) ... there weren't very young kids some of them you know, and teenagers and Mum would come in and there would be a big row about something and she would have to leave. Now her tasks were to discuss that and to take control with Dad together - for them to be seen together on this rather than have ... Dad saying one thing and she saying another ... so they were literally to confront the kids together and discuss it with them as parents to children and to be seen to be together and, yeah. They took that on board too and were doing that. I don't know how successful that was - I didn't get much feedback at the time.*

**Were these tasks that you sort of actively directed them to do or?**

*These tasks came around because of the problems they were raising. I wouldn't have thought about the TV for example and they would have said this is an issue and I would have said OK...*

**Did that come out of the miracle question?**

*That would have developed literally from the miracle - they would have been saying things like: I'd be able to come in and watch the TV, turn on a channel and maybe watch a programme for myself, particularly for the Mum because the Dad was more out doing his jogging and gardening and things. She was more into watching TV and a lot of soaps and stuff at night so she was sort of saying: yes as part of my miracle I would like to be able in the evening to sit down and watch TV and ... It was from the miracle, literally though.*

***Did you take a break before you devised feedback, or tasks?***

*Did I take a which?*

***A break?***

*No, In fact what would have happened would have been that they would have gone out to make some tea or something - so there would have been sort of a natural break there anyway ... I think I probably did ask for a cup of tea at some stage ... (laughs)*

***So, can you tell me then, going back a second time, what was the picture then?***

*Well, they were more positive. I mean, they were - it just seemed very different in a sense that they were just delighted in themselves that they had actually done this - that they had chatted for three hours which was just amazing for them and they wouldn't have talked at all for years literally talked about things. They would have talked at each other and about, you know did you make tea and did you do this and did you do that ... but apparently they actually talked for those three hours and actually communicated, and feelings came up and issues of personal stuff. I was just taken aback, I wouldn't have expected them to get that far, I would have just thought a few minutes here and there to start off with ... but they went fairly in the deep end, you know.*

***And what do you think was the different sense of themselves that they had?***

*I think it was more - to me it was a sense of: we can do this. It was a sense of maybe being positive about their own sense of control over something. And also it was a different perspective - pursuing it quite differently. And there were - there were positive things in their life too. That they can actually develop them and if they got to a stage where, I mean it sounds totally impossible, but if they get to a stage where they feel that they can actually push out all the, or expand the good times, the positive experiences throughout the day well there is no room left for the problem then anyway - you know the way (laughs). Well, obviously, realistically, there are always issues and problems that come up in families but particular ones are causing serious dysfunction that they would actually deal with, you know.*

***So it was a very effective piece of work. How long were they involved with the family before?***

*They were, it would have been a year before that I think, nearly a year and they had been through the Mater Child Guidance, Claid Mor.*

***And had they not engaged with those agencies or?***

*Only Dad did, in fact eventually. He was regularly going in and Mam didn't. I think she went to Northside Counselling, in fact I referred them to some alternatives locally and partly in fact that was because I was not able to start doing any work with them anyway. And the other thing was that they had been through the services before, with me actually, about four years before that, and with similar issues about the son, which were resolved at that stage. He was in Primary school at the time and basically he just misbehaved himself for whatever period of time and then apparently it emerged again.*

***So, in relation to your attempts to use it or your use of it in other cases what generally was the kind of way in which it panned out?***

*Well, I mean the first thing I noticed after the sessions that went on with that particular family, I walked out of that family feeling brilliant -for me personally you know, feeling totally relieved of responsibility in terms of what they were doing, and felt that now they are actually participating, and taking control of their own lives and will change things if they want to change things - you know the way. So, I just felt, I'm no longer carrying this literally.*

***So it had quite an impact on you as well?***

*Oh, it was excellent. I just felt, yeah, this could really have a good impact in terms of the, even the stress of work and being tired, you know and then again would have sort of a ripple effect and people sort of going to the next family session down the road not as tired - you know the way. And feeling a bit more energised.*

### **11: Example of using the miracle question and being laughed at**

*'we started off with problem-free talk, and ... the miracle question ... first of all they looked at us like we had three heads and then they roared laughing at us ... that's where they were at, and I think part of it was they weren't ready to consider that. They were stuck and they were happy to be stuck and maybe that's what we also learnt – they were quite happy to be where they were, and neither of them really wanted the child back in the house at that time.*

***Did that come out of the questioning or?***

*It came out more when we talked about it afterwards, and in a sense that actually cleared things for us as well, because I think we sort of believed that most people want their child back and then you have to accept that not everybody does'.*

### **12 : A 'returnee' who had moved into a new setting and who reinvented the approach to fit better with her new client group**

The client was a woman in her mid-forties with a chronic illness,

*... quite a distressing illness which effects vertigo and balance...She would have been very much focused on the problem... worrying about when she was next going to fall over ... her focusing on it actually made the situation very much worse for herself'.*

The worker carried out about four family sessions with the client, her husband and their two children.

*I would have used the Miracle Question with her ... and her miracle was that she wouldn't have the disease and I was [thinking] 'right, do I go with this or do I try to change it?. But I decided to go with it, so it was a matter of then talking about: well, if you didn't have the disease, what would you do? And getting her to visualise what would be the things that would be different, and I would have asked her then to scale where she was and she would have put herself right down at one ... then we looked at the fact that miracles don't happen ... and 7, if your quality of life was a 7, so I turned it around to be quality of life rather than the disease being gone ... and then she visualised the kind of things she would be doing. And the family – I asked each of them to say what their miracle would be – and for the husband, the miracle wasn't around the disease at all, it was that he would be able to be patient with her and for the children it was that their mother would be there for them. And that was quite useful for her because she didn't perceive it in that way. She had felt that they were not there for her. She'd forgotten that they felt she was absent because she was so absorbed in her illness...She found it useful for her husband to say that it was around being patient because that was what she had felt – she had felt that he wasn't patient with her....So we would have used it around that and what would be different and how she would notice that it was different and I got each of them to say how it would be for them and we followed it on from there'.*

It was a time limited piece of work because the husband was going away on business but the worker continued to 'offer the woman support' individually for a period of three months 'until she felt able to let go'. The worker received feedback from the client that the work had been helpful.

*What she said she got out of it was that it helped her to actually look at all the things she could do from her list of what she wanted to do...and the things she could tackle and the things that she could go and do, and each step that she took, she focused on something that she had visualised trying to do. It was just going to the shops, because she started to suffer from agoraphobia as a result of her fear of being dizzy in public. So she would have found that it did help her to focus on the things she could still do in her life and her family would have felt that it helped them – they would have been quite impatient with her and they felt it helped them to help her to focus on doing those things as well.*

In this case, the work had taken place about fourteen months before the interview, a month after the second training course. The client had recontacted the worker just before the research interview:

*I have to contact her again for another appointment. She wants me to make contact again with her husband around being patient with her',*

indicating that although the use of SFT techniques were useful for a time, problems had resurfaced in the relationship with her husband. That the client re-established contact with the worker with a specific request for 'more of the same' work can be seen as a positive initiative.

### **13: Use by a therapeutic worker in a health board setting, highlighting its value in eliciting the client's view**

*She is separated from her husband and she's got a second partner ... Her violent husband had left and she lost custody of her two younger children. Had another child then but her older family had been coming back to her ... one of them was a drug addict and she was absolutely worn out. I had been kind of thinking that there were no anSocial Workerers for this woman's problems ... I was thinking that she'd be better off without this boy ... if he could go back to the father, do this, do that and the other and leave her alone, she would be better able to cope with what's she has left. But in actual fact, when I made this approach, she actually quite liked the idea of the boy coming back to her, right? It was very important to her. And I hadn't really allowed her that, do you know what I mean? ... the things that she wanted from him were very small, they weren't that he'd be cured ... it was really that he would maybe keep to his own space and stuff like that. And she was saying how kind he was and good he was in all sorts of other areas and ... I felt I'd never allowed her look at that other part of him. And now he's still in the house, but because she has stopped and thought about all his positive bits, she was able to cope with that...Now, I'm not saying it's perfect. I'm just saying that it gave her the opportunity to turn it right around, where it was so negative and wasn't going anywhere'.*

### **14 : A confirmed adopter in a child psychiatry setting**

*I wouldn't go through the stages or the break. Not really. I would use it more as a model where your orientation is positive and where your feedback to the client is always looking for their resources, strengths and skills. I'd also use ... looking for exceptions ... the coping questions and I would use various versions of the miracle question ... I use scaling questions a lot as well ...*

*'There was a girl of 6. She had a number of fears about going to school and there was quite serious anxiety and she would talk about being worried ... and her parents would get very upset about this, particularly her mother, because she would just keep talking about it, and that was the presenting problem. Now, psychodynamically, it was all related because there was mother's own issues from the past and so forth, and in terms of their own relationship and so forth ... but I adopted the approach ... spent a long time building up the child's positives: what she was doing right in school; and also the parents'*

positives: what they were doing ... with the discovery of one or two exceptions to the worries which involved Dad being involved really and that was my hunch about it as well. Slightly strategic use - if the Dad was more involved it reduced the anxiety. So we set a number of tasks for them which were around them being more involved ... and then we went away and the next session they came back with a lot of positives - the child had taken on board a lot of positives. And the Dad had just been on a positive thinking course: he had to do affirmation and he taught the child to do it in the previous two weeks: if you don't worry about it, you'd be OK the next day and she logged herself and so forth - a six year old. And the six year old child used to say her prayers every evening and he used to say some of those - which of course reinforced it all, so that was wonderful ... It was also remarkable that it was the child's own belief in herself that changed ... using the child's strengths - that she was quite a religious child in ways, a spiritual child who did believe in things. So she took on board the strength to do that and by the strategic - by the mother coping with her own anxiety by her accepting that it was OK for her child to worry sometimes.

### **15 : A confirmed adopter in a child psychiatry setting**

*I suppose the one I'm thinking about is Bernie, and she had twins who were extremely aggressive to one another and difficult to manage in the house and she is an unmarried mother living with her elderly parents. And ... her whole focus on them then was: you better get that Dan one into care because he is a total disgrace, you know ... They were 8 when I started - they 're about 10 now ... And the interesting thing about them was that the first time, after the first time, like I was much more confident - with them, and then after the second time I was not only self confident with them but I was enthusiastic with them and that made a big difference, you know ...*

#### ***Had you already been involved with them?***

*Oh yeah they had had speech assessment and all the usual assessments you get in a place like this , you know. And really, it was a parenting issue and it was a question of her self confidence really, you know. Of her ability to parent and not recognising what she was doing well. She would come in and she would say, something like: I put him in time out and he's banged the door down and she would have a hundred, ten of those things to tell you and not one would she tell you of all the times that things went well, you know. So when I changed the thing around ... I just got her to talk about the times that, when it worked*

#### ***Exceptions?***

*Yeah, and when things were going OK and when her Mum and Dad weren't giving out and like how was it then, you know. And then like, how far on was she in terms of getting it and I was expecting her to say ... the way she was talking that she was going to be a nine or ten, you know. But when she said three, you know I was surprised ... I was genuinely surprised you know. I suppose my surprise and pleasure at her being that far - I let her see that. And then we worked on that, and we talked about the miracle question and I mean her miracles were very small really you know? They weren't a lot. Like they were like, when they'd get up in the morning, you know that instead of Dan coming down and grumpy and complaining about having to get dressed before he came down you know what I mean.? It was very small stuff, but it changed the whole ... I mean they no longer come here day by day.*

#### ***And were you using it with Bernie by herself or?***

*No. it was the whole family. No, I opted for the whole family approach with them. Now in another case I opted to use it just with the little boy because it was a school based problem and you wouldn't get the teacher in.*



***So you adapt it to suit individual?***

*Yeah, you have to do that, you know. But I mean, this was a case that community care and everybody would have been involved with.*

***This is Bernie?***

*Yeah. Yeah.*

***So was there a lot of concern about it?***

*Oh yeah, major stuff.*

***And over what period of time would you have used it?***

*With Bernie? After the last two days [of training] it is almost like she is psychic, she turned up. And I saw her, I think, how long did we see her? I saw her for five or six sessions, which was very little. It really was very little. And then I didn't see her again and she, no she came back herself because her mother said that she needed a top up which was about seven months later, and we talked about what she was doing well and how she was coping and then there was during the summer there was an issue with a neighbour, and she came down and I thought we were going to, it sounded horrendous now and I thought we'd have a long session and I thought I would still in, I would be retiring before this problem was solved (laughs) and in fact it only took three sessions. It was very, very good now. And maybe I'm picking the ones that will work, I'm not sure ... As a result [of using the approach] I suppose I have held onto people even as they haven't stayed as long, which is really good. I would see what were chronic cases become better able to manage and I can think of two off the top of my head now, and they would only need refills rather than ongoing. Every six months or whatever'.*

**16: A confirmed adopter in child psychiatry who worried about the risk of using SFT for cases with domestic violence concerns**

***And any cases where you think it [SFT] is absolutely not applicable?***

*It does not seem to work in a family where the father is very violent – it is that you can't get at the father, if you are trying to. I had a father, what seemed to be a fairly easy enough case here recently and I tried to use it, but I couldn't understand how he couldn't hear what his wife was saying. And I could just see them sitting in front of me here and she was buying into it [SFT] and talking about the child but he wouldn't...it was over a period of time that I discovered, after about two sessions that what was really happening was that he was very abusive and her [the wife] having even an idea of her own caused havoc when she went home.*

***And do you think that using that approach [SFT] actually helped her to tell you or?***

*I don't know. I was very scared because he was very violent when they went home because he had planned to take control of the session ... I started to talk about ... that he [the client, the son] seemed to be a nice boy....[the boy and his parents] seemed to be getting on very well so there must be things that went well...and she [the mother] was only too delighted to take that line and to talk about what goes well for them and what worked well in the family and that. And he was furious. He was furious and he kept saying: No, no, it's not like that at all.*

***And during the session he was doing that?***

*Yeah, yeah. He was extremely negative. And if she [the mother] was describing something that the boy would have done, he [the father] would interrupt and he would say 'Oh, yeah, he did that BUT...you know?'*

***So he was discounting?***

*He discounted, he undermined everything she said. You know. But he was very angry because, and it was almost like, you know, you two women. You know.*

***And what way did the session end?***

*Well in the end...I said we need to meet again...And he was saying: 'Yeah, well, you haven't told us anything. Haven't done anything for us so far.' You know. And they left and we gave them another appointment and they came back and she [the mother] said nothing [about the violence at home]. And I didn't know what was going on ... And he didn't come the next time.*

***Did she turn up?***

*Yeah, she came then and talked [about the domestic violence].*

***So, do you think from what you are saying that you'd warn against using it [SFT] in those situations.?***

*...I have no way of knowing. And he might have beaten her up anyway, you know? Because he might have beaten her up for being obviously a bad mother or whatever. There is no way of knowing. Yeah. He would have found some other reason. But she was very clued into her little fella [her son, the referred child] and she wanted to present him well, you know, once she got the opening.*

This worker then indicated that there were other situations where she would 'instinctively' not use SFT, particularly with men she perceived to be controlling or 'obsessional neurotic' clients. In these situations she would instead

*... be very direct, up front with somebody like that. We are here because Johnny is in trouble in school or because there are worries about him because he is very withdrawn. '*

This alternative approach to SFT she viewed as being 'safer for everyone'.

**17. medical social worker using SFT with a bereaved client**

The worker described a client whose wife had died of cancer three years previously, with whom she had carried out some bereavement counselling at the time of the death.

*'And out of the blue about a year and a half later he turned up again, very distressed, couldn't cope. His great difficulty was first of all he had taken to drink, and he had stopped that. And then he had taken to women in a big way. And really it was all about trying to help him to "live in his own house" again, get over being unable to be alone or be by himself in the house. And to go back and be able to take up his normal life again, to take care of his children. He wanted to spend an awful lot of time talking about these relationships or his drinking. And I just said that wouldn't take us anywhere. So I began to use the scaling and miracle question –and if he was better what would he do? And he described his miracle and how he would be when he could take up his normal life again. And if he was feeling better on a Saturday morning he might take a walk down along the canal. And he talked about this and it included this walk along the canal. And he began to describe this walk that he had last done two years previously. And I almost fell off the chair because it was a perfect example of how he'd actually done it. And he was able, he could live his life again. It really worked incredibly well. It did make a big difference. I used the miracle question: what would he do? Went through the day and tracked it slowly. Used scaling quite a lot as well.*

**APPENDIX E – RESPONDENT GROUP BY SETTING AT TIME OF INTERVIEW.**

Child protection community care	18 practitioners	5 Managers
Specialist community care	7 practitioners	-
Fostering Unit	4 Practitioners	1 Manager
Child Psychiatry	5 Practitioners	1 Practitioner/Manager
Medical Social Work	4 Practitioners	-
Elderly Medicine	2 Practitioners	-
Adult Psychiatry	-	1 Practitioner/Manager
Counselling service	1 Practitioners	-
Voluntary organisations (2)	-	2 Practitioner/Manager
Residential Child Care	-	1 Manager

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