

12-2016

## Volume 2 Issue 2 - Complete

Follow this and additional works at: <https://digitalscholarship.unlv.edu/journalsfp>

---

### Recommended Citation

(2016) "Volume 2 Issue 2 - Complete," *Journal of Solution Focused Practices*: Vol. 2: Iss. 2, Article 11.  
Available at: <https://digitalscholarship.unlv.edu/journalsfp/vol2/iss2/11>

This Article is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Article in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Article has been accepted for inclusion in *Journal of Solution Focused Practices* by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact [digitalscholarship@unlv.edu](mailto:digitalscholarship@unlv.edu).

et al.: Volume 2 Issue 2 - Complete

# Journal of Solution-Focused Brief Therapy

Volume 2, Number 2 — December 2016

---

## **IN THIS ISSUE**

Editorial — *Michael Durrant*

### **Peer-reviewed articles**

SFBT 2.0: The next generation of Solution-Focused Brief Therapy has already arrived — *Mark McKergow*

Scale development and psychometric qualities of the Resilience Doughnut tool. A valid, Solution-Focused and ecological measure of resilience with Australian adolescents — *Lyn Worsley and Odin Hjemdal*

Evaluating the effectiveness of a resilience program for children and young people in a private Australian psychology clinic — *Kaitlyn Miller, Lyn Worsley, Tanya Hanstock and Megan Valentine*

### **Interview**

Solution-Focused work in the busy Emergency Department of a large city hospital. An interview with David Hains — *Michael Durrant*

### **Forum**

Words — *Evan George*

### **Reviews**

John Henden: *Preventing suicide: The Solution-Focused approach (2nd edition)*

Rayya Ghul: *The power of the next small step: What's the best that could hapopen?*

Kidge Burns: *Focus on solutions: A health professional's guide (Revised second edition)*

J  
S  
F  
B  
T



# Journal of Solution-Focused Brief Therapy

Volume 2, Number 2 — 2016

---

|                        |     |
|------------------------|-----|
| <b>EDITORIAL</b> ..... | vii |
|------------------------|-----|

*Michael Durrant*

## PEER-REVIEWED PAPERS

|  |   |
|--|---|
| SFBT 2.0: The next generation of Solution-Focused Brief Therapy<br>has already arrived ..... | 1 |
|--|---|

*Mark McKergow*

|  |    |
|--|----|
| Scale development and psychometric qualities of the Resilience<br>Doughnut tool. A valid, Solution-Focused and ecological measure<br>of resilience with Australian adolescents ..... | 18 |
|--|----|

*Lyn Worsley and Odin Hjemdal*

|   |    |
|---|----|
| Evaluating the effectiveness of a resilience program for children<br>and young people in a private Australian psychology clinic ..... | 37 |
|---|----|

*Kaitlyn Miller, Lyn Worsley, Tanya Hanstock and Megan Valentine*

## INTERVIEW

|   |    |
|---|----|
| Solution-Focused work in the busy Emergency Department of a<br>large city hospital. An interview with David Hains ..... | 61 |
|---|----|

*Michael Durrant*

## FORUM

|             |    |
|-------------|----|
| Words ..... | 72 |
|-------------|----|

*Evan George (with comments by Don Coles, Thorana Nelson and Ian Johnsen)*

|                      |    |
|----------------------|----|
| <b>REVIEWS</b> ..... | 78 |
|----------------------|----|

## Journal of Solution-Focused Brief Therapy (JSFBT)

ISSN 2203-6784

Published by:  
Australasian Association for Solution-Focused Brief Therapy Inc. (AASFBT)  
PO Box 372  
KURRAJONG NSW 2758  
Australia

[www.solutionfocused.org.au](http://www.solutionfocused.org.au)

JSFBT is published bi-annually in July and December. Members of the Australasian Association for Solution-Focused Brief Therapy receive a subscription as part of their membership. Individual subscriptions from non-members may be purchased (currently \$AU 120). Members of "partner" Solution-Focused associations may purchase a subscription for a reduced rate (currently \$AU 75).

For subscription details, see [www.solutionfocused.org.au/sfbt.html](http://www.solutionfocused.org.au/sfbt.html)

### Rights and permissions:

All articles published in JSFBT become the property of the journal. To obtain rights to reproduce any material published in the journal, please email [jsfbt@solutionfocused.org.au](mailto:jsfbt@solutionfocused.org.au). Authors have full rights to alter and/or republish their own material with appropriate acknowledgement.

### Advertising:

To advertise in the journal, please contact [jsfbt@solutionfocused.org.au](mailto:jsfbt@solutionfocused.org.au)

### NOTE:

All views expressed in papers published in this journal reflect the opinions of the individual author(s) and are not the views of the Editorial Board or of the Australasian Association for Solution-Focused Brief Therapy.

Produced in Australia by Print a Book.

## **EDITORIAL BOARD**

### **Editor:**

Michael Durrant, *Brief Therapy Institute of Sydney, Australia*

### **Associate Editors:**

Rayya Ghul, *Programme Director, Post-graduate Certificate in Learning and Teaching in Higher Education and Senior Lecturer in Occupational Therapy, Canterbury Christ Church University, UK*

Dr Frank Thomas, *Professor of Counseling and Counselor Education, College of Education, Texas Christian University, Fort Worth, USA*

### **Editorial Board:**

Dr Mark Beyebach, *Assistant Professor, Departamento Psicología y Pedagogía, Universidad Pública de Navarra, Pamplona, Spain*

Brian Cade, *Private practice, Cirencester, UK*

Dr Susan Colmar, *Program Director, School Counselling and School Psychology, Faculty of Education and Social Work, University of Sydney, Australia*

Dr Peter De Jong, *Emeritus Professor, School of Social Work, Calvin College, Michigan, USA*

Kirsten Dierolf, *Director, SolutionsAcademy, Germany*

Dr Cynthia Franklin, *Stiernberg/Spencer Family Professor in Mental Health, The University of Texas at Austin, USA*

Dr Adam Froerer, *Associate Director, Master of Family Therapy program, School of Medicine, Mercer University, Atlanta, USA*

Brent Gardiner, *Programme Leader Counselling & Guidance, Institute of Education, Massey University, Palmerston North, New Zealand*

Dr Wei-Su Hsu, *Professor, Department of Educational Psychology and Counseling, National Taiwan Normal University, Taiwan*

Chris Iveson, *Co-Director, BRIEF, London, UK*

Dr Michael Kelly, *Associate Professor, School of Social Work, Loyola University, Chicago, USA*

Dr Sara Smock Jordan, *Associate Professor, Community, Family and Addiction Services, Texas Tech University, Lubbock, USA*

Dr Harry Korman, *Director, SIKT, Malmö, Sweden*

Dr Mo Yee Lee, *Professor, College of Social Work, Ohio State University, Columbus, USA*

Dr Alasdair Macdonald, *Consultant Psychiatrist, Dorset HealthCare University Founda-*

*tion NHS Trust, UK*

Dr Mark McKergow, *Director, Centre for Solutions Focus at Work and Visiting Research Fellow, University of Hertfordshire, London, UK*

Dr Gale Miller, *Professor of Sociology and Research Professor of Social and Cultural Sciences, Marquette University, Milwaukee, USA*

Dr Thorana Nelson, *Professor Emerita of Marriage and Family Therapy, Utah State University, USA*

Karin Thorslund, *Co-Director, Göteborgs Institut för Lösningfokus, Göteborgs, Sweden*

Dr Andrew Turnell, *Director, Resolutions Consultancy, Perth, Australia*

Dr Svea van der Hoorn, *Visiting Senior Lecturer and Examiner, Graduate School of Business, University of Cape Town, South Africa*

Dr Trish Walsh, *Social work educator & researcher, School of Social Work and Social Policy, Trinity College Dublin, Ireland*

John Wheeler, *Director, Solution Focused Trainers, and External Lecturer in Social Work, Durham University, UK*

## EDITORIAL POLICY

The *Journal of Solution-Focused Brief Therapy* is a scholarly journal that aims to support the Solution-Focused community through the publication of high-quality research in outcome, effectiveness or process of the Solution-Focused approach and the publication of high quality theoretical and/or case-study related material in the area of Solution-Focused practice.

While the journal is published by the Australasian (Australian and New Zealand) SF Association, it is clearly intended as a service to the international Solution-Focused community. The Editorial Board has a minority of Australians and includes prominent Solution-Focused people from a number of different countries — and we will continue to seek to expand this. In addition, we offer discount subscriptions to members of (currently) a dozen different national SF “partner” associations.

The journal invites submissions as follows:

**Research reports** — We are committed to helping expand the evidence base for Solution-Focused Brief Therapy. The journal seeks scholarly papers that report the process and results of quantitative and/or qualitative research that seeks to explore the effectiveness of Solution-Focused Brief Therapy or seeks to explore aspects of the Solution-Focused process. We are also committed to research reports being “user-friendly” and so invite authors submitting research-based papers to address specifically the

implications or relevance of their research findings to Solution-Focused practitioners.

**Theoretical papers** — The Solution-Focused approach raises many issues relating to psychotherapy theory, to our basic assumptions of working therapeutically and to the philosophical stance adopted by Solution-Focused practitioners. The journal welcomes papers that explore these issues and which offer novel arguments or perspectives on these issues.

**Case study/Practice-related papers** — We are committed to the journal being related to Solution-Focused PRACTICE. Therefore, we invite papers that explore the experience and perspective of practitioners. This might be a single case study, with significant analysis and reflection on the therapeutic process and which then distils some principles or insights which might be replicable, or it might be a paper which explores a series of clinical/practical cases and which seeks to draw out overarching principles which might be used by others. Please discuss your ideas with the Editor!

**Not just “therapy”** — The Journal recognises that many useful and interesting manifestations of the Solution-Focused approach occur in settings that are not to do with therapy. Nonetheless, Solution-Focused interventions are all concerned with helping to facilitate change. The journal is called the *Journal of Solution-Focused Brief Therapy*, at least in part in homage to our heritage. Nonetheless, the journal welcomes submissions that explore the use of Solution-Focused ideas in other settings. The journal enjoys a collegial relationship with the journal *Interaction: The Journal of Solution-Focused in Organisations* and, where appropriate, will discuss which journal offers the more appropriate publication forum.

## SUBMISSION OF MANUSCRIPTS

### Manuscripts

Manuscripts should be sent to the Editor as Microsoft Word or Apple Pages word processing documents. Please do not submit your manuscript elsewhere at the same time. Please send the manuscript double-spaced with ample margins and a brief running head. The title of the paper should appear on the first page. Since all manuscripts will be blind reviewed, please include names, affiliations, etc. of the author or authors on a SEPARATE first page. Please also include on this (or a next) page details of any grants that have supported the research, any conference presentations relating to the paper, any potential (or even perceived) conflicts of interest.

Spelling should be anglicised, with -ise endings and English spelling of words such as colour, counselling, and so on. Solution-Focused Brief Therapy and Solution-Focused may be abbreviated to SFBT and SF after the first mention.

References should follow the format of the American Psychological Association (Pub-



lication Manual of the American Psychological Association, 6th ed.). Papers should include an abstract of no more than 150 words.

Any tables, figures or illustrations should be supplied on separate pages (or in separate computer files) in black and white and their position indicated in the main document. For any images or photographs not created by the author, the submission must include written permission to reproduce the material signed by the copyright holder.

We would expect that papers will ordinarily be a maximum of 5,000 words; however, this limit is negotiable if the content of the paper warrants more.

### **Clinical/client material**

The Journal's policy is that any actual clinical detail in a paper (including, but not limited to, therapy transcripts, client/patient history, descriptions of the therapy process) should have signed consent from the clients/patients for the material to be published. If a paper includes clinical material or descriptions, please include a declaration, signed by the first author, either that signed consent of clients/patients, specifically for the publication of their clinical information in this journal, has been obtained and is available for review OR that clinical material has been altered in such a way as to disguise the identity of any people.

### **Review**

Manuscripts will be reviewed by at least two members of the Editorial Board, who will be asked to recommend that the paper be accepted or rejected for publication; however, final decision about publication rests with the Editor. Reviewers will also be asked to indicate what kinds of changes might be needed in order for the paper to be published. Where reviewers have indicated that changes are required or recommended, we are happy to work with authors to review amended submissions with a view to achieving publication. When the reviewers both recommend that the paper not be accepted, and make no recommendations for changes, and when the Editor accepts this recommendation, no further consideration of the paper will be given. When the reviewers (and the Editor) suggest that your paper, while it might have merit, does not meet the requirements for this journal, we will endeavour to suggest other journals to which the author might submit the paper; however, we are under no obligation to help achieve publication.

Where one or more authors of a paper is a member of the Editorial Board, that person will take no part in the review process and the review process will still be anonymous to the author or authors.

Send manuscripts to: [michael@briefsfocused.com.au](mailto:michael@briefsfocused.com.au)

## Editorial

**Michael Durrant**

Welcome to this issue of the *Journal of Solution-Focused Brief Therapy*.

Steve de Shazer had some clear ideas about what was — and wasn't — to be regarded as Solution-Focused Brief Therapy and they offered a "definition", including four defining aspects of the approach de Shazer and Berg (1997). More recently, Trepper et al. (2012) have offered a "manual" for Solution-Focused Brief Therapy. These publications represent a continuum of Solution-Focused orthodoxy, with development and evolution over time. Others have suggested that, now that the SFBT founders are no longer with us, it is almost "anything goes" under the Solution-Focused heading — a position against which I argued recently (Durrant, 2016).

In the world of computer software, we are used to incremental and evolutionary upgrades which are contrasted with the (often more rare) major version upgrades.

Mark McKergow — whilst clearly not a supporter of the view that Solution-Focused is whatever you want it to be — suggests that there has been such a major version upgrade to Solution-Focused practice and that it is important to be clear about these changes. Thus, he suggests what he terms *SFBT 2.0* and outlines what he sees as these major developments and changes in emphasis.

Whilst Solution-Focus is not the same as a focus on strengths and/or on resilience, all three share a common theoretical and philosophical tendency to focus on people's success and ways of coping rather than on people's deficiencies or pathology. Research in the area of resilience is important to us because it adds support for the broader philosophical standpoint from which Solution-Focused comes. Thus, I am pleased that this issue of the journal includes two significant research papers relating to measures of resilience in

children and young people, and using *The Resilience Doughnut* — an Australian model for conceptualising resilience (Worsley, 2011).

Our interview this issue is with David Hains, a mental health nurse in Adelaide, South Australia who has pioneered the use of SFBT within the mental health Emergency Department setting. David coordinated the recent Australian and New Zealand Solution-Focused Conference in Adelaide, which was a successful culmination (so far) of David's Solution-Focused journey in Adelaide.

One of the key factors leading to the decision to establish this journal was the recognition of the importance of having an academic-standard, peer-reviewed journal of Solution-Focused practice. At the same time, both the members of the Editorial Board and the publishers (the Board of the Australasian Association for Solution-Focused Brief Therapy) recognise that many of our readers are primarily practitioners. Thus, we seek to juggle academic and practice emphases.

In this issue, we introduce a new, occasional feature, the *Forum*. In this section, something published online or in a niche publication — which might raise interesting or even contentious ideas about SFBT — will be reprinted and two or three people invited to write comments. In this first *Forum*, Evan George has some thoughts (originally posted online) about words ... and how we should be aware (or beware) of them. Our three invited commenters all — unfortunately — agree with Evan's thoughts but offer some interesting thoughts of their own. We hope you find this new feature useful, and we will be including other, more practice-based features in coming issues.

## References

- de Shazer, S. & Berg, I. K. (1997). 'What works?' Remarks on research aspects of Solution-Focused Brief Therapy. *Journal of Family Therapy*, 19(2), 121–124.
- Durrant, M. (2016). Confessions of an unashamed Solution-Focused purist: What is (and isn't) Solution-Focused? *Journal of Solution-Focused Brief Therapy*, 2(1), 40–49.
- Trepper, T. S., McCollum, E. E., deJong, P., Korman, H., Gingerich, W. J., & Franklin, C. (2011). Solution-Focused Brief Therapy Treatment Manual. In C. Franklin, T. S. Trepper, W. J. Gingerich, & E. E. McCollum (Eds.), *Solution Focused Brief Therapy: A Handbook of Evidence-Based Practice* (pp. 20–38). Oxford University Press.
- Worsley, L. (2011). *The Resilience Doughnut. The secret of strong kids*. Sydney: Griffin Press.

## **SFBT 2.0: The next generation of Solution-Focused Brief Therapy has already arrived**

**Mark McKergow**

Centre for Solutions Focus at Work, UK

This paper seeks to consolidate developments in Solution Focused Brief Therapy (SFBT) over the past decade. I conclude that we have already seen the arrival of a kind of new form of SFBT, focused firmly on descriptions and even simpler in form than the original SFBT developed by Steve de Shazer, Insoo Kim Berg and colleagues. This new form is still definitely SFBT in terms of the priorities and focus of the original progenitors, but it has also left behind many elements which were inherited during the initial development from the previous family therapy and brief therapy traditions. The name 'SFBT 2.0' is proposed, to help prevent confusion with earlier forms while maintaining that this is not a new therapy but an important evolution of existing practice.

In Solution-Focused Brief Therapy (SFBT) the question “how would you notice that the miracle has happened” is often asked. This is not at all the same as how to make the miracle happen — more like beaming ahead into the future and exploring the difference that the miracle makes in everyday life. It leads to a conversation about noticing change, rather than striving for it from scratch — about discovering that change is already happening as a precursor to building on it.

I suggest that the signs of such a change in our own practice are becoming more and more noticeable. In this paper I will outline these signs and how I think that they are showing that we are already proceeding in new directions. As such, this paper is not a call to action. I am not proposing a new form of SFBT, I am trying to give more clarity and shape to what is going on, and propose that it's time for us to recognise and use these developments rather than pretending that we are all still on the same page from the early 1990s. These latest versions are already in print, but they are not clearly flagged as new.

That there are different forms of SFBT under the same banner risks causing confusion among newcomers, and indeed among more experienced practitioners who see different ideas and methods under the same title.

As these newer versions are still unmistakably SFBT, it would not be appropriate to seek to give them a new name. However, there is now enough difference that it would be worth making a distinction. In the manner of major new releases of software, I propose that 'SFBT 2.0' might be a working title.

In this paper I will seek to describe the differences and innovations between SFBT 2.0 and what we might call SFBT 1.0, the 'original' version. Even this is not easy to pin down in detail, following Steve de Shazer's insistence on many occasions that 'there is no orthodoxy'. However, these distinctions are becoming larger and increasingly important, and the field is at risk of becoming even more muddled.

## **SFBT 1.0**

SFBT emerged gradually during the second half of the 1980s from an extensive programme of empirical research at the Brief Family Therapy Center (BFTC), Milwaukee under the direction of Steve de Shazer, Insoo Kim Berg and colleagues. De Shazer and Berg were highly influenced by the brief therapy approach of the Mental Research Institute (MRI), Palo Alto, and set out to develop this approach in their own centre. Indeed, MRI stalwart John Weakland remained both supervisor and close friend to Steve de Shazer until the former's death in 1995. This background is important in the way language is initially used in SFBT, as we shall see.

Through the first half of the 1980s the BFTC team developed their brief therapy ideas, with Steve de Shazer producing two books (S de Shazer, 1982, 1985) building on the idea of finding patterns and developing ideas based on Ericksonian methods (for example the 'crystal ball technique') developing interventions which could be seen as 'skeleton keys' to unlock cases. The first traces of SFBT as we know it appeared in a key 1986 paper (de Shazer et al., 1986) and consolidated in the 1988 book *Clues: Investigating Solutions in Brief Therapy* (de Shazer, 1988). Gale Miller, engaged by BFTC as an observer/researcher, spent time at the Center in 1984 and again from 1989. He says that the practice changed markedly during this time:

Keep in mind that in 1984 they were not doing SF therapy, they were doing something very much like Steve's first book (de Shazer, 1982) — I called it ecosystemic therapy. It was very much informed by the Palo Alto Group (the Mental Research Institute) ... [In 1989] I discovered

that it was a very very different place. You could see that they had made a dramatic move in the direction of SF practice, different kinds of assumptions, much less systemic, much less time on developing clever interventions, much less time mapping troubles or problems, it was much more focussed on solutions and more fluid. (McKergow, 2009 p.79)

Many practitioners around the world recall starting their SF practice by reading *Clues*, which contained the main ingredients of SFBT (although not with the same balance of elements — much more emphasis is given to constructing exceptions, with conversations around a hypothetical solution reserved for cases where no exceptions can be found). Steve de Shazer went on to write two books which were less about the ‘how to’ than attempting to add some intellectual rigour to their findings (de Shazer, 1991, 1994). By the early 1990s the approach was gaining a foothold internationally, and the formation of the European Brief Therapy Association (EBTA) in 1994 gave a place for practitioners to gather, share and develop.

Developments through the 1990s and into the 2000s included more focus on research (and the development of an EBTA research protocol to try to ensure some clarity about what counted as SFBT for research purposes), and the application of SFBT ideas in further areas of therapy and of life (schools, organisations, social work, prisons, etc). Through the first decade of the 2000s there were hundreds of research studies published (Macdonald, 2011), and in 2012 an authoritative collection was curated by Cynthia Franklin and published through Oxford University Press (Franklin, Trepper, McCollum, & Gingerich, 2012). The second chapter of this book (Trepper et al., 2012) is entitled ‘Solution Focused Brief Therapy Treatment Manual’ and gives a good description of what we might call ‘classic SFBT’.

- Pre-session change
- Goals (preferably small)
- Miracle question
- Scaling questions
- Constructing solutions and exceptions
- Coping questions (if appropriate/necessary)
- Break, compliments about strengths and resources
- Homework (either designed by client or experiment suggested by therapist)

This summary will serve as a base line for what comes next. I don't think there is anything controversial about it as a broad statement of practice.

## **Emerging developments**

During the 2000 and into the 2010s there have been some interesting developments emerging in the SFBT field which seem to me to extend and change the classic SFBT 1.0 treatment manual given above. Many of these developments are mentioned, without too much ceremony, by Shennan and Iveson (2011) and indeed in other works from the BRIEF team and others (Iveson, George, & Ratner, 2011; Iveson & McKergow, 2016; Ratner, 2014; Ratner, George, & Iveson, 2012). However, in some cases I fear that the authors have not made enough effort to distinguish their own innovations from established practice. I would summarise the distinctions as:

- From action language to description language
- From questions to 'rooms' and 'tools'
- From goals to best hopes/common project
- Preferred futures and scales — same questions, different aims
- From exceptions to instances — clearer focus on discussions about the past and present
- Losing hangovers from family therapy
- Ending the session — no tasks or even actions, more appreciative summarising
- Let's look at each of these in turn.

## **From action language to description language**

From the earliest days, MRI model brief therapy valued specific concrete descriptive information (see Weakland & Fisch, 1992 for a latter day summary, which also states that Steve de Shazer attended an early MRI brief therapy workshop in 1972). The MRI approach, a real paradigm-buster in mental health, is to view such problems not as 'inside' the patient but as some kind of result from the communication patterns between the client and those around them. The focus on specific concrete descriptive information is a way to stop being drawn in to internal psychological hypothesising, and instead focus on the interactions — who is doing what, with whom, when and in what order.

This, in the MRI model, is the key to finding ways to disrupt the pattern which is maintaining the problematic state and opening the doors for something different to happen, by devising a behavioural intervention. Once something different IS happening, the client can be advised to do more of it to promote the new and better pattern of behaviour.

This focus on specific language is carried over into SFBT 1.0. Indeed, de Shazer and others consciously named their landmark paper Brief Therapy: Focused Solution Development after the MRI's earlier contribution (Weakland, Fisch, Watzlawick, & Bodin, 1974), as a way of indicating that these two approaches were connected. However, this concrete detail is now much more about what the client wants, the day after the miracle, what is working and so on, rather than about the problem pattern. The overall purposes of both avoiding mentalistic hypothesising and focusing on specifics are still there, as is the focus on gathering information with the goal of devising interventions or giving tasks.

If we look now at the recent 'descriptive turn' described by Shennan and Iveson, this same focus on specific concrete descriptive information is present. However, now this detail is not for the therapist to devise interventions, it's much more for the client to say and hear and respond to. If anything, the level of detail is even greater than before — for example, the 'cuddle' case related by Iveson and McKergow (2016) where a five-second cuddle takes as many minutes to describe. (Sharper eyed readers may have noticed that the title of their paper, Brief Therapy: Focused Description Development, consciously echoes both the papers mentioned in the previous paragraph, again in tribute to an evolving approach.)

The goal of the therapy is changed here. The therapist is not seeking to gather information to devise interventions. Rather, the therapist's role is to help the client expand the details of their descriptions, which then become more and more littered with tiny specifics which might easily suggest themselves as actions for the client. Once the client is talking, say, about the day after the miracle, the therapist will be encouraging more detailed talk about the client and those around them (a very conscious echo of the MRI half a century ago) but in terms of details of what the client wants rather than the problem patterns. Some very simple questions can help this, such as

- What would be the first tiny signs you would notice that [X] was starting to happen? What else?
- Who would be the first person to notice that [X] was happening? What would they notice, that would tell them that [X] was happening? What else?



Note that [X] doesn't have to be specific here — it might be a simple restatement of best hopes, or even just 'this' in the conversation. These questions help render things detailed, even from very foggy and unclear starting places.

So, the role of therapist changes from a sorter-of-detail (to figure out the relevant details for intervention design) into an expander-of-detail (to help the client immerse themselves in their descriptions of better futures, pasts and presents). The vocabulary shifts from 'doing' to 'noticing'. It seems that Steve de Shazer and Insoo Kim Berg were onto a part of this shift of emphasis as early as 1992 in their paper *Doing Therapy: A post-structural revision* (de Shazer & Berg, 1992) where they discuss the idea of grammar-shifts during the session. However, they may not have grasped all the consequences of such a shift at that time. This new role also comes into play in many of the other distinctions I will relate below.

### **From questions to 'rooms' and 'tools'**

Questions have always been at the heart of SFBT. Indeed, the original videos produced by BFTC showing Steve de Shazer and Insoo Kim Berg at work are subtitled to help viewers keep up with what's happening in the session. The titles say 'Miracle Question', 'Scaling Question' and so on. The focus is on the question. There are now even books collecting huge numbers of 'SF questions' even now books about '1001 SF Questions' (Bannink, 2010), as if a question alone can be 'solution-focused'. (Any question can be asked in a myriad of different ways, and only some of them might be SF.)

Of course such questions are an important element of SF practice. However, the point of these questions is not simply to be asked — it is to start or build on a section of the interview/session. A miracle question and a single answer may make a little progress, but the real meat lies in what happens next — the expansion of the answers into descriptions in conversation.

The miracle question or scaling question is not simply a question, but the start of a much longer piece of conversation. It therefore makes sense to focus on these chunks of conversation, rather than the questions alone, as discrete elements. So, a 'preferred future' conversation is a miracle question PLUS all the follow ups about first tiny signs that the miracle has happened, who else might notice, what would they notice, what happens next, what difference that makes, to whom, and so on.

Chris Iveson has been talking about an 'art gallery' metaphor for a therapy conversation. This art gallery has a series of 'rooms' with different things to look at and examine. These rooms might include (Figure 1):

- Ticket office — getting some best hopes from the client, a 'ticket' to pro-

ceed with the work.

- Preferred future gallery — a set of pictures or descriptions of a better future for the client and their kin (wrong word) with these best hopes realised
- Instances gallery — a set of pictures or images of instances in the past or present that connect with this preferred future (which may be constructed using a scale from 1–10)
- Gift shop — the final room, which may feature a series of pictures or images of N+1, smaller pieces or signs along the way that progress is being made.

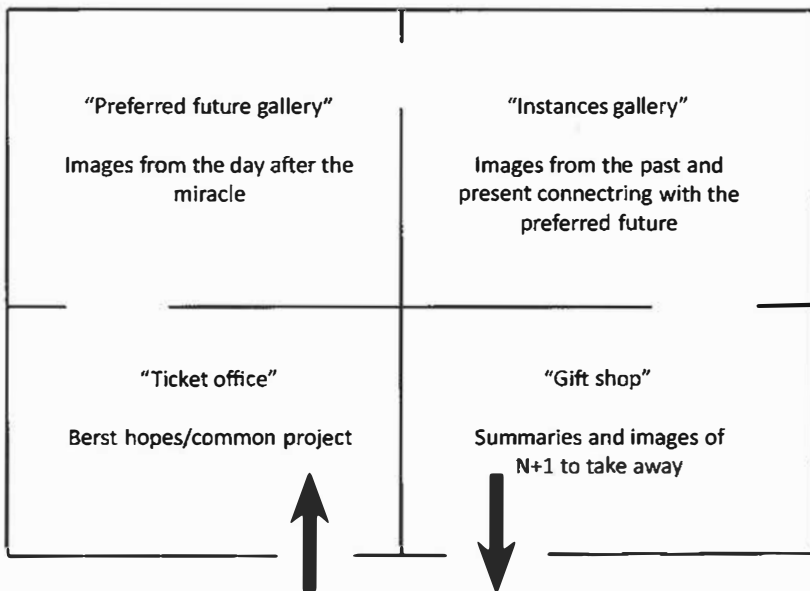


Figure 1. A solution-focused art gallery (after Chris Iveson)

Like the Instances gallery, Adam Froerer of Mercer University talks of a Resources room (Froerer, 2017), where different elements of the client's life showing their resources are gathered. The point of this metaphor is not that each room must be visited in order with no backtracking allowed. Far from it — although there is definitely a direction of travel implied from entrance to exit, during the session the client and therapist may spend more time in one

room than in others, may go back and revisit something, or perhaps discover something else they hadn't noticed before, and so on. This is not a recipe but a guide to what will inevitably be an individual journey.

These 'rooms' help the practitioner keep track of where they are and what's going on in the conversation. It's generally good to stay in one room for a while, not dashing frantically from one room to another. If, during a preferred future conversation, an interesting and relevant 'instance' appears (more on this concept later), the therapist will make a note of it and go to visit it later, rather than diverting immediately to see it now and losing the thread of the preferred future conversation. Therapist and client can move from room to room together, backtracking if necessary. The key distinction here is making the most of each 'room' or phase, rather than leaping between rooms (a tendency I observe in many absolute beginners to SFBT, who seem to want to apply all the questions at once!).

This development was presaged by the work of Jackson and McKergow (2002, 2007) on 'solutions tools'. These too were an attempt to find a larger unit of conversation than the question/answer, to help learner practitioners and coaches keep track. Jackson and McKergow attempted to give snappy names to these tools, such as Future Perfect (preferred future) and Counters (including instances and also relevant resources) (Figure 2).

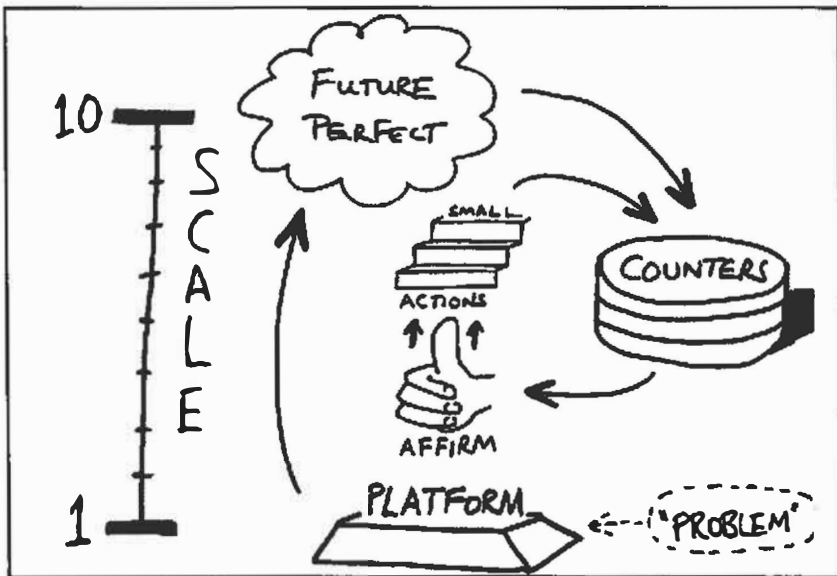


Figure 2. Solutions Tools (from Jackson and McKergow, 2002)

These terms don't always translate well into other languages, but they have proved durable over the past decade and more in helping practitioners to make the most of the conversation they are having (by sticking with it) rather than rushing off to other conversations when a tempting morsel is dangled by the client. There is also the advantage that the tools concept does not impose a 'correct order' for the tools to be utilised, giving flexibility to the practitioner within an easy-to-carry framework.

### **From goals to best hopes/common project**

There has long been discussion as to the nature of goals in SFBT. In the early days, it seems to me that there was a focus on (small specific behavioural) goals as a way of helping the general move away from psychological hypothesising and towards some kind of discussion about what was desired by the client. The idea of 'goal oriented' was a useful marker to distinguish from other 'insight oriented' or 'deep' practices. However, the emergent nature of SFBT means that the process will conclude not when the client's goals are necessarily met, but when the client is satisfied that they can carry on their lives under their own steam – whether that connects with their initial goals or not.

The move towards starting with asking about the client's 'best hopes', as BRIEF and others do, is a step away from goals. A goal is a specific thing to be accomplished (possibly by a specific date). A hope is something in the future, something desired and yet not present (entirely) at the moment. A best hope is that, but more ambitious and perhaps even scarcely possible. (This is distinguished right away from the 'reasons for coming to therapy, which are usually in the past and not desired by anyone.)

The answers to best hopes, and such answers may not come immediately, are a way to define the theme or nature of the work. Harry Korman (Korman, 2004) has written about defining a 'common project' – common between the client and therapist — upon which they both agree to work for a while. Others including Michael Hjerth (in Klingenstierna, 2001) and Jackson & McKergow (2002) have described this stage as a 'platform', a place to stand when the work begins. It's good to remember the initial peroration that Steve de Shazer used in his later years: "There are no guarantees, but I will do my best, and I hope you will too. (Looking at client to get some kind of affirmative response)." This is offering a clear contract — I will work on your hopes together with you, and it will take both of us working together.

This is not goal setting. It's a title or theme for the work, one which can be put into practice right away in asking a miracle question or a scale to embark on the next phase of the interview. This leaves everything open to change

and to evolution as things go on. If goals are set and then clung to, even small goals can put you in gaol (jail) with unexpected developments meaning that what was initially a reasonable goal now turns either into an easy stroll or an impossible dream.

### **Preferred futures and scales — same questions, different aims**

The discussion of 'preferred future' (the day after the miracle, which usually happens tonight) and scaling questions have long been, and continue to be, central elements of SF practice. However, with the move from gathering information to design interventions to building rich and detailed descriptions, the aims of these processes also change. So, the therapist has a 'slightly different head on' when they lead into these discussions.

Rather than listening for behavioural patterns which might be amplified and repeated, the practitioner is more concerned with helping the client to develop and enrich their descriptions, particularly in interactional terms. Who will be doing what, in response to whom, with which tiny noticeable signs? Note how close this appears to the original MRI detailed language idea, but with a different aim. The purpose is not unlocking the whole case with an 'aha' moment, much more a gradual building of detail which somehow leaves the client in a different place at the end — even if there is no particular wizz-bang 'aha' moment involved.

### **From exceptions to instances — clearer focus on discussions about the past and present**

Perhaps THE key element in the beginning of SFBT was the art of finding and constructing exceptions — times when the problem should have happened but didn't, or happened less. Indeed, back in 1988 when *Clues* was published this was the main strategy for the therapist — the miracle question and hypothetical futures only being discussed if no exceptions could be found. The idea was that the presence of these exceptions showed that not only was the occurrence of the problem not inevitable (as it often appeared to the client) but also that the client could, by clever action and observation, start to produce these exceptions deliberately. This opened the door to control and then reduction of the problematic behaviours, with the client in the driving seat.

The original idea of exception finding — times when the problem doesn't happen or happens less — includes everything apart from the problem happening at its worst. This is a very broad category! These days it is much more usual for the therapist to embark on some kind of preferred future con-

versation first, which allows for a different and better defined alternative – ‘instances’ of this preferred future happening in full or in part, or past events which seem to prefigure this hoped-for future. This gives a much clearer focus on events which relate not simply to the absence or reduction of the problem, but connect to the best hopes and preferred future described by the client. This is a more focused inquiry, and may therefore bring more immediately useful and relevant ideas into the conversation. . Others might refer to these various elements as ‘pieces of better’ (as distinct from just ‘pieces of different’) — and of course to discuss that, we need some understanding of what ‘better’ means in the context.

One way to start such a conversation is with the classic ‘scale from 1–10’ question, where 10 is the preferred future or best hopes realised (there is no need for a full miracle question in order to simply evoke the clients stated best hopes). The client thinks for a moment and then may say ‘3’ or whatever. Of course, the next piece of conversation is ‘how come you are 3 on the scale and not lower?’ — again a classic piece of SF work which sits broadly unchanged, apart from the new focus on building rich descriptions rather than trying to deliberately prompt the client to action .

### **Losing hangovers from family therapy**

MRI model brief therapy emerged from the same MRI team who had developed family therapy some years before (in the 1950s and 1960s). That group had become accustomed to using the trapping and paraphernalia of family therapy — a special therapy room equipped with a one-way mirror, a team of therapists sitting behind the mirror (unseen by the client), a telephone to communicate with the therapist in the room with the client. The family therapy routine was for the lead therapist to carry out the session with the client (perhaps being prompted by colleagues to ask certain questions) and then leave the client alone while they retreated to the team room behind the mirror. There, a conference would ensue about who had noticed what, what kind of intervention might be appropriate, and how it might be ‘sold’ to the client as being useful. The therapist would then return to the client and give an end-of-session message, including the intervention.

The idea of giving compliments to the client first emerged as a strategic move in these end-of-session messages. Someone observed that offering the client compliments about them, their handling of the situation so far, their useful strengths and qualities, produced a ‘yes-set’ — the client nodded along in agreement with these helpful points, and so was more inclined to accept the therapists’ intervention.

If we continue to explore the new role of the therapist as being the elicitor of detailed descriptions rather than the designer of interventions, then some key things follow:

1. There is no need for a team any more. The conversation is for the client to hear, and the single therapist is part of that. The idea of others watching, hidden from view, seems not only costly but also rather creepy.
2. There is therefore no need for a break, as there is no intervention to design and nobody with whom to consult. In the original 1997 EBTA research definition, the break was one of six elements which would indicate that therapy was properly 'solution-focused'. Times have changed.
3. There is not the same need for compliments in a sustained barrage, as the prelude to selling some kind of intervention. That is not to say that compliments are forbidden — more that the purpose of them changes into potential reframing of difficulties and normalising of challenges, and can be used at any time during the session.
4. And of course there is no intervention. Some (including BRIEF) would even say that any conversation about possible actions and next steps is unnecessary — the client will do something if they see fit, and if they don't see fit then there is no point asking about it. I personally, working in an organisational context, might still ask the client about their thinking on possible next small steps — the idea being that it's very normal to agree actions in these contexts, to the extent that some people assume that if they haven't agreed an action then they positively don't have to do anything, which is not the impression I seek at all. The focus is usually on helping them focus on small actions, much more likely to get done than large actions and so more likely to make a difference. Whatever, this is now at most a light touch final question to the clients rather than a complex intervention with coin tossing, pretending, formula first session tasks, or acting differently on alternate days of the week, and all the other aspects that featured in the strategic family therapy playbook.

### **Ending the session — no tasks or actions, more appreciative summarising**

We have just seen that the end of the session has lost many of the trappings which used to be taken as read in the early days. There is no ritual of break,

compliments, tasks. However, we have to bring things to a close in some way. Appreciative summarising by the practitioner can usefully be done here — it shows you've been listening, and offers the client the chance to hear some of the things they've been saying again, perhaps in a different order. One way to add an extra piece of detail which may help the client to look at smaller (and hence more do-able) details is to engage in a description of tiny signs that (N+1) has been reached.

Another way to engage in a kind of discussion about actions without talking about actions is to scale the client's confidence. Evan George (George, 2017) has recently written about three ways to use confidence scales at the end of a session:

- Confidence of being able to make progress on your best hopes (scale of 1-10, followed by discussion of what is helping to be that high). This can be particularly useful at the end of a first session.
- Confidence of maintaining the changes you have made (scale of 1-10, again followed by discussion about what helps things to be that high, and perhaps even higher). This can be useful then therapy is coming to an end.
- Confidence of maintaining change and of reaching 'good enough'. This concept of 'good enough' can be a useful way to gauge progress, in terms not of reaching a 10 but rather in the client's own experience at the moment.

One other aspects of ending sessions in SFBT 2.0 is an even clearer commitment to offering power to the client, in terms of whether there might be another session and when might be a good time for it. So we might expect to see less of 'please make an appointment for next Tuesday', and more of 'I hope that's been useful for you ... would you like to come back to continue our work together?'. Steve de Shazer always said that therapy should take as many sessions as it takes and not one more, so we should be looking to help the client decide if and when they wish to return. And if they think that's enough, then it's cause for gentle celebration.

## Conclusion

In conclusion, we might summarise the similarities and differences between SFBT 1.0 and SFBT 2.0 as follows.(See table 1, next page).

It seems to me that while these two columns have a lot in common, both explicitly and implicitly, there are enough substantial differences to warrant a distinction being made. In particular the role of the practitioner is quite dif-



| SFBT 1.0  | SFBT 2.0   |
|---|--|
| <b><i>Remaining the same</i></b>                  |  |
| Focus on what the client wants                    | Focus on what the client wants   |
| Radical acceptance of what the client says        | Radical acceptance of what the client says                                     |
| Miracle questions and scales                      | Miracle questions and scales   |
| Specific concrete details observable descriptions | Specific concrete details observable descriptions                              |
| Coping questions (if appropriate/necessary)       | Coping questions (if appropriate/necessary)                                    |
| 'What's better?' follow up                        | 'What's better?' follow up   |
| <b><i>Looking different</i></b>                   |  |
| Focus on questions                                | Focus on chunks of conversation, 'rooms', 'tools'                              |
| Questions to produce information for tasks        | Questions to develop client's descriptions                                     |
| Problem-free talk                                 | Straight into 'best hopes'   |
| Goals (preferably small)                          | Best hopes, differences the best hopes will make to all concerned              |
| Exceptions (to the problem)                       | Instances (of things connected with the best hopes/preferred future)           |
| Compliments at the end of the session             | Appreciative summarising through the session, no compliment barrage at the end |
| Break and end-of-session message                  | Offering chance of next session if needed/wished.                              |

*Table 1: Summary table*

ferent, going from someone who might see themselves as a skilful task master to one whose role is to help the client expand their descriptions of what is wanted. In the former outlook the change will happen after the session, when the client goes out and does something differently (or views something differently). In the latter outlook, important change is happening right there in the session, in the conversation

This is not to say that SFBT 1.0 is wrong, or bad, or outdated, or anything like that. There are people doing it right now, and having good results with their clients. However, if we are to progress SFBT it would seem to be important that we be clear about what we're doing and not doing. I suspect that many practitioners are probably doing some from each column right now. The current situation, where all the above happens under the same heading, does not seem to me to be a helpful place for practitioners, learners or indeed researchers. There is some initial research (Shennan and Iveson, 2011) that what I term SFBT 2.0 is more brief—and hence better, by the aesthetics of brief therapy—than the more established version. There is also experience—by me over several years and by others—that this newer version of SFBT is effective, efficient, and even more elegant than the previous versions. This of course must be tested. But it will be impossible to test if we don't make a distinction at the start.

## References

- Bannink, F. (2010). *1001 Solution-Focused Questions*. New York: WW Norton.
- de Shazer, S. (1982). *Patterns of brief family therapy: An ecosystemic approach*. New York: Guilford Press.
- de Shazer, S. (1985). *Keys to solution in brief therapy*. New York: WW Norton.
- de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York: WW Norton.
- de Shazer, S. (1991). *Putting difference to work*. New York: WW Norton.
- de Shazer, S. (1994). *Words were originally magic*. New York: WW Norton.
- de Shazer, S., & Berg, I. (1992). Doing therapy: A post-structural re-vision. *Journal of Marital and Family Therapy*, 18(1), 71–81.
- De Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weinert-Davis, M. (1986). Brief therapy: focused solution development. *Family Process*, 25, 207–221.
- Franklin, C., Trepper, T. S., McCollum, E. E., & Gingerich, W. J. (2012). *Solution-focused brief therapy: A handbook of evidence-based practice*. New York: Oxford University Press.
- Froerer, A. (2017.) *The Power of Solution Focused Language*. Presentation at the Solution Focused Safari conference, Johannesburg, South Africa, 31 March 2017.
- George, E. (2017). Scaling up our practice. Retrieved April 17, 2017, from <https://www.facebook.com/BRIEF.SolutionFocus/posts/10155063623559976?pnref=story>
- Iveson, C., George, E., & Ratner, H. (2011). *Brief coaching: A Solution Focused approach*. London: Routledge.

- Iveson, C., & McKergow, M. (2016). Brief therapy: Focused description development. *Journal of Solution Focused Brief Therapy*, 2(1), 1–17.
- Jackson, P. Z., & McKergow, M. (2002). *The Solutions Focus: The SIMPLE way to positive change (First edition)*. London: Nicholas Brealey.
- Jackson, P. Z., & McKergow, M. (2007). *The Solutions Focus: Making Coaching and Change SIMPLE*. London: Nicholas Brealey.
- Klingenstierna, C. (2001). *Lösningfokuserad gruppterapi vid långtidssjukskrivning-en jämförande studie med deltagare sjukskrivna mer än sex månader*. (Solution-focused group therapy with long term sickness absence — a comparative study with participants on sick leave more than six months.) Unpublished M.Sc. Psychology thesis, Uppsala University, Uppsala, Sweden.
- Korman, H. (2004). *The Common Project*. Retrieved November 24, 2015, from <http://www.sikt.nu/wp-content/uploads/2015/06/Creating-a-common-project.pdf>
- Macdonald, A. J. (2011). *Solution-focused therapy: Theory, research & practice (second edition)*. Sage Publications.
- McKergow, M. (2009). Gale Miller: The man behind the mirror behind the mirror at BFTC. *InterAction-The Journal of Solution Focus in Organisations*, 1(1), 78–88.
- Ratner, H. and Yusuf, D. (2015). *Brief coaching with children and young people: A Solution Focused approach*. London: Routledge
- Ratner, H., George, E., & Iveson, C. (2012). *Solution Focused Brief Therapy: 100 Key Points and Techniques (Vol. 8)*. Routledge.
- Shennan, G., & Iveson, C. (2011). From solution to description: Practice and research in tandem. In C. Franklin, T. S. Trepper, E. E. McCollum, & W. J. Gingerich (Eds.), *Solution-Focused Brief Therapy: A Handbook of Evidence-Based Practice* (pp. 281–298). Oxford: Oxford University Press.
- Trepper, T. S., McCollum, E. E., deJong, P., Korman, H., Gingerich, W. J., & Franklin, C. (2012). Solution-Focused Brief Therapy Treatment Manual. In C. Franklin, T. S. Trepper, W. J. Gingerich, & E. E. McCollum (Eds.), *Solution Focused Brief Therapy: A Handbook of Evidence-Based Practice* (pp. 20–38). Oxford University Press.
- Weakland, J. H., & Fisch, R. (1992). Brief therapy — MRI style. In S. H. Budman, M. Hoyt, & S. Friedman (Eds.), *The First Session in Brief Therapy* (pp. 306–323). Guilford Press.
- Weakland, J. H., Fisch, R., Watzlawick, P., & Bodin, A. M. (1974). Brief therapy: Focused problem resolution. *Family Process*, 13(2), 141–168.

---

## About the author:

Mark McKergow is Director of the Centre for Solutions Focus at Work, Edinburgh, Scotland. As well as being a pioneer in using SF ideas in organisational

settings, he has been a visiting research fellow in the Department of Philosophy, University of Hertfordshire (UK) since 2010, where he engaged in expanding the academic roots and connections of SFBT with respect to the latest post-Wittgenstein thinking such as enactive cognition and narrative philosophy.

Email: [mark@swork.com](mailto:mark@swork.com)

# **Scale development and psychometric qualities of the Resilience Doughnut tool. A valid, Solution-Focused and ecological measure of resilience with Australian adolescents**

**Lyn Worsley<sup>1</sup> and Odin Hjemdal<sup>2</sup>**

1. The Resilience Centre, Epping. 2. Norwegian University of Science and Technology, Trondheim.

The Resilience Doughnut is an ecological and Solution-Focused model outlining the seven contexts where resilience skills can be developed. The premise of this study was to test the psychometric properties of the online resilience doughnut measurement tool. The analysis contains item analysis and confirmatory factor analysis. Each context was explored as a separate subtest. The results showed the model to be a good fit with Cronbach alpha coefficient between .63 and .87. Correlations were conducted with the subscales of the Strength and Difficulties (SDQ) questionnaire and The Resilience scale for Adolescents (READ) revealing that the stronger the resources (RD) the greater the levels of personal and social competence and the lower the emotional and behavioural difficulties experienced. Implications for further study are discussed noting the validity of enhancing existing strong social resources to develop resilience.

People who display resilience show they are in a process of sorting, prioritising and ordering their most helpful resources in order to activate recovery, sustain life or grow through trauma or adversity (Zautra, Arewasikporn & Davis, 2010). Furthermore, resilience research has shown that resource and process focused interventions are more successful in enhancing a young person's healthy development (Masten & Coatsworth, 1998). Resilience is also defined as a process, not a fixed state, so ideally interventions that enhance that process should use a Solution-Focused and strength approach (Masten & Wright, 2010).

Some of the key characteristics of a Solution-Focused approach as noted by de Shazer and Berg (1997) are; using a miracle question to help a client and therapist to envisage their preferred future, scaling the process, complimenting on the strengths involved so far, and assigning homework or experiments that may activate these strengths (Durrant, 2016).

The Resilience Doughnut is a strength-based ecological model, which uses a Solution-Focused approach to activate existing strong resources in a person's life to help them towards their preferred future. As a dynamic conversational tool, the Resilience Doughnut model prompts questions that envisage the preferred future, highlights the strong resources and provides a platform to compliment how they have worked so far (Worsley, 2011, 2012). The resources are seen in the everyday ordinary relationships that exist at any point in time and can be activated by combining the strengths in a homework activity or experiment.

It is therefore of value for people, to accurately assess their own resources as an indication of the possible pathways for further personal development. A measure should preferably be based on either a definition or a theory, however there are very many different definitions of resilience and no common consensus. Thus basing a measure on a theory or a model would be the remaining option. The Resilience Doughnut model (Worsley, 2014a), originated in response to working with youth in a range of environments from clinical psychological practice, youth work, corrective services, and paediatric medicine and education facilities. It was observed that the most useful interventions (Domínguez & Arford, 2010; Riley & Masten, 2005; Steinhart & Dolbier, 2008) took into account where and with whom the young person was more likely to develop the navigation and negotiation skills, in order to help them cope with their difficulties. From observation in clinical practice, it became clear that in order to help vulnerable young adults to develop resilience it may be more useful to measure the potential pathways and contexts where resilience can develop, than to quantify their resilience at any one time (Ben-Arieh, 2005; Burgin & Steck, 2009).

The Resilience Doughnut model was developed after examining research into the ecological and developmental assets, which build a child's healthy self-esteem and social competence that contribute to building resilience (Bronfenbrenner, 2005; Masten & Wright, 2010; Sharkey, You & Schnoebelen, 2008; Tol, Jordans, Reis & de Jong, 2009; Ungar & Liebenberg, 2009). The model has been helpful for future planning and programming with youth in a number of contexts (Worsley, 2014) and has the potential to influence policy development to effect positive changes in young people and as a strengthening tool against mental health difficulties.

## Psychological Resilience

From previous research (Benard, 2004; Grotberg, 1995; McGraw, Moore, Fuller & Bates, 2008; M. Rutter, 2006; Ungar, Brown, Liebenberg, Cheung & Levine, 2008) it seems that there are three dynamics that help to define the process of resilience. Firstly there are internal or personal characteristics that enable a person to bounce back from adversity (Benard, 2004; Grotberg, 1995). Secondly there are external or environmental influences that contribute to the building of these internal assets or personal competencies (Fuller, McGraw & Goodyear, 1998; Ungar, 2008; Ungar & Lerner, 2008; Werner & Smith, 2001). Thirdly, the interaction of the internal characteristics with the external available resources, which hinder or enhance a resilience mindset ultimately affect an individual's reaction to adversity (Rutter, 2008).

The Resilience Doughnut model is a simple diagram of two circles, one inside the other, which conceptually represents the interaction of these internal characteristics and external contexts in developing resilience. The model is based on the definition that resilience is a process of continual development of personal competence while negotiating available resources in the face of adversity.

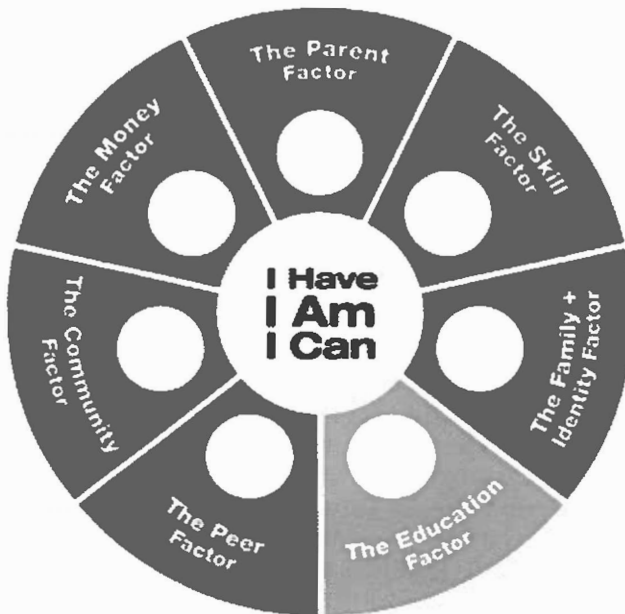


Figure 1. The Resilience Doughnut framework

The inner circle represents the internal individual characteristics and the outer circle represents the external contexts within which an individual develops. The external contexts are divided into seven sections, each of which has been shown in the research to contribute to building individual resilience. The interactional nature of the internal and external worlds of an individual is represented by the visual connection between the inner circles of the framework within the external circle. Thus, the two circles, an inner circle and an external circle divided into seven external contexts, represent the essence of the resilience doughnut model (see Figure 1).

### **The internal structure of the Resilience Doughnut**

The inner circle of the framework, representing the internal characteristics of an individual showing resilience, give expression to a number of concepts, which repeatedly appear in research. These concepts contribute to raising self-esteem (Benard, 2004; Frydenberg, 2007; Grotberg, 1995; Werner E., 1992), self-efficacy (Benard, 2004; H. W. Marsh, Martin & Hau, 2006), and an individual's awareness of their available resources (McDonald & Mair, 2010). In combination they contribute to resilience as noted by Grotberg's I have, I am and I can categories (1995). These categories are the basis of the internal individual concepts for the Resilience Doughnut, which interact with the external contexts.

### **The external structure of the Resilience Doughnut.**

The outer circle of the framework, divided into seven sections, (Fry & Debats, 2010; Gilgun, Klein & Pranis, 2000; Windle & Woods, 2004) addresses research, which shows the environmental contexts where resilience can be hindered or developed. These seven contexts, are labelled parent, skill, family, education, peer, community and money. A number of research constructs make up each context with some common features between each context (Worsley, 2011).

### **Scale development process**

The items in the Resilience Doughnut measure were initially generated from the research on each of the seven sections of external factors in the model (Table 1). This formed the preliminary Resilience Doughnut tool, which divided the external section into seven subtests with ten items within each subtest. The items were simple statements, beginning with "I have", "I am", or



“I can”, with a dichotomous response Yes or No (Worsley, 2011).

|                  |   |
|------------------|---|
| <b>Parent</b>    | Discipline style and Decision-making, warmth/affection<br>Monitoring/control/Independence<br>Parent satisfaction and purpose<br>Parent reliability and adaptability |
| <b>Skill</b>     | Optimistic thinking, Success, achievement, persistence<br>Organisation, self-discipline, confidence   |
| <b>Family</b>    | Connectedness, Traditions and events, Family networks<br>Belonging and valued<br>Tough times  |
| <b>Education</b> | Belonging, Inclusive and respectful environment<br>Teacher expectations, optimism, relationship<br>School organisation and Extra activities, Engagement             |
| <b>Peer</b>      | Belonging<br>Conflict<br>Group identity<br>Conformity, cooperation, selfcontrol and regulation  |
| <b>Community</b> | Informal network, Local resources, neighbourhood<br>Organised groups, religious youth, sport club   |
| <b>Money</b>     | Chores, Earning and spending money,<br>Family work ethic  |

Table 1. External contexts of the Resilience doughnut framework with constructs that informed items in the preliminary resilience doughnut tool.

To review the items a small sample of young people (30 students, aged 12-15 years, 18 males and 12 females) who attended two state high schools in Sydney’s southern suburbs and 150 adults who had attended the Resilience Doughnut training workshops over an 18-month period (primarily teachers, school counsellors, case workers and youth-workers) were selected. Signed permission was sought from parents and guardians of the youth prior to the interviews.

Ten items for each of the seven subtests were generated initially based on the above empirical research and the students then tested each item. Stu-

dents were asked to fill out the questionnaire and give comments and items were revised in accordance with comments.

Each subtest was also tested with the sample of adults who worked with young people in various contexts as recommended by DeVellis (2003). Further modifications were made to the items, with particular consideration as to the helpfulness of a conversational tool around each of the contexts. These adult experts on adolescents, suggested multiple times that the positively worded items would help the adults and young people feel confident in discussing their strengths within each of the seven contexts. For this reason, negatively worded items were removed and the language used by the sample subjects replaced a number of negative items.

Based on the feedback from the young people and the expert adults, the dichotomous response format was changed to a Likert scale of six, giving a forced choice. The format adapted to the suggestions of the youth people and is as follows; 0=xxx=no never, 1=xx=almost never, 2=x=not really, 3= $\sqrt{}$ = sort of, 4= $\sqrt{\sqrt{}}$ =sometimes, 5= $\sqrt{\sqrt{\sqrt{}}}$ =yes always. Only the ticks and crosses were visible with the wording appearing when the pointer hovered over the area. The number allocated to the response was not visible to the students.

This continuum allowed for a wider range of responses and stimulated further discussion with subsequent representative samples. The scores were collated for each item and then divided by 5 giving a total score out of 10 for each subtest. These total scores were visible to the students.

## **Aim.**

The present study explores the psychometric properties of the Resilience Doughnut (RD) scale in relation to reliability and indications of validity. To test the hypothesis that each factor represents external contextual factors they were treated as independent subtests and confirmatory factor analysis was undertaken to explore the measurement model of each of the subtests separately. It was hypothesised that each subtest would factorise according to the items representing the research constructs.

Correlation between each of the seven subtests from the RD and the Resilience Scale for Adolescents (READ) and the Strength and Difficulties Questionnaire (SDQ) was undertaken in order to explore indications of construct validity. It was hypothesised that the seven subtests would show positive significant correlation with the subscales of the READ measure and negative significant correlation with the difficulties subscales and a positive significant correlation with the prosocial subscale of the SDQ.

## Method

### *Participants*

In all, 867 adolescents were included from seven high schools in three states in Australia. There were 75% female and 25% male participants. Their mean age was 15.20 (SD=1.71). Each school sought permission from the participant's parents or guardians to be involved in the study. The seven schools were representative of a wide range of students from low to high socio economic status across three states in Australia. Two of the schools were for Catholic girls, (low fees), and a third one for boys (high fees) in middle class areas in Melbourne and Sydney. The other four schools comprised of one state boys high school (no fee) in Sydney, a coeducational school in a country town of NSW, a coeducational school in WA, (each from a low socio economic areas) and a private school in Sydney with high fees from a high socio economic area.

### *Measures*

*The Resilience Scale for Adolescents (READ)*, (Hjemdal, Friborg, Stiles, Martinussen & Rosenvinge, 2006; Soest, Mossige, Stefansen & Hjemdal, 2010) has 28 items with five subscales of personal ( $\alpha=.76$ ) and social competence ( $\alpha=.77$ ), structured style ( $\alpha=.69$ ), awareness of social resources ( $\alpha=.79$ ) and family cohesion ( $\alpha=.89$ ). Higher scores indicate higher levels of resilience on the specific factors. The READ is a measure of protective factors associated with resilience that has shown good validity. Previous studies have shown the READ has a negative correlation with depressive and social anxiety symptoms, as well as the ability to predict depressive symptoms controlling for age, gender, stressful life events and levels of anxiety symptoms (Hjemdal, Aune, Reinfejl, Stiles & Friborg, 2007; Hjemdal, Vogel, Solem, Hagen & Stiles, 2011). In another large study a moderate negative correlation was found with symptoms of emotional disorders and self-harm, and mild negative correlation with externalizing behaviour like para-suicide, alcohol intoxication, smoking, using illicit drugs violent behaviour and being exposed to bullying (von Soest, Mossing, Stefansen & Hjemdal, 2010).

*The Strength & Difficulties Questionnaire (SDQ)* (Goodman, 1997; Hawes & Dadds, 2004) has 33 items with five subscales: emotional symptoms ( $\alpha=.66$ ), conduct problems ( $\alpha=.66$ ), hyperactivity ( $\alpha=.80$ ), peer difficulties ( $\alpha=.59$ ), and pro-social behaviours ( $\alpha=.70$ ). Higher scores indicate a higher presence of emotional, conduct, hyperactivity, and peer difficulties with the exception of pro-social behaviours where higher scores indicate presence of higher levels of positive characteristics. The SDQ has been used widely in Australia

and is regularly used as a pre-screening tool for students to determine behavioural or emotional difficulties. It has high discriminate validity and has cut-off points to classify subjects as normal, borderline or abnormal. The total difficulties score is determined by the sum of the scales excluding the prosocial scale. The prosocial scale assesses a child's resources, ability to relate well with peers and show care for others (Silva, Osorio & Loureiro, 2015).

*The Resilience Doughnut tool (RD)* (Worsley, 2014b) which has 70 items, divided into seven subtests titled parent, skill, family, education, peer, community and money.

### **Data analysis**

The means and standard deviations as well as correlations were estimated using IBM SPSS 22.0. The confirmatory factor analyses was undertaken using Mplus 7.31 (Muthén & Muthén, 1998-2014). Because each of the subtests are separate tests relating to specific themes, each of the subtests were run independently in confirmatory factor analyses (CFA). The CFA was conducted with the asymptotically distribution free method to examine the overall fit of the measurement model; error terms in the items were allowed to correlate. The fit indices derived were the comparative fit index (CFI) and the incremental fit index (IFI), both with values  $\geq .90$  being regarded as acceptable model fits. The root mean square error of approximation (RMSEA) values  $\leq .05$  was considered a good model fit. Pearson correlations were calculated between the factor scores and measures of psychological distress.

### **Procedure**

The three measures were completed on a purpose build computer program which enabled the results to be collated immediately. Students had access to the results of their Resilience Doughnut highlighting the three strongest factors. The time taken to complete the questionnaires was 20-30 minutes depending on the student's literacy level. The consistency with the instructions and delivery of the measures, as well as the student report of more honest responses to the questions was ensured using the on line format.

After receiving permission from parents, students were then sent log in details to complete the tests. Some of the schools used class time for the students to complete the tests while others required the students to complete the questionnaires at home.

De-identified data from each student was then immediately available for the researchers in order to run the statistical analysis.

## Results

### Confirmatory factor analysis

Participant included in the confirmatory factor analysis was 867. The results from the CFA are presented in Table 2. For the subtest, Parents, no changes were undertaken. CFI and TLI were within acceptable range. The RMSEA was slightly above the recommended limit but still within the acceptable range. For the subtest Skills the initial results were  $\chi^2(35)=142.99$ ,  $p < .000$ , CFI=.934, TLI=.899, RMSEA=.070, (CI=.059 - .082). Based on the modification indices, two items were deleted and then the fit indices were within the acceptable range. For the subtest Family, the fit indices were within the acceptable range with 10 items. For the subtest Education the initial results were  $\chi^2(35)=202.27$ ,  $p < .000$ , CFI=.910, TLI=.885, RMSEA=.074, (CI=.065 - .084). The modification indices indicated that one item could be deleted, and then the fit indices were within the acceptable range. For the subtest Peer the initial results were  $\chi^2(35)=148.66$ ,  $p < .000$ , CFI=.876, TLI=.840, RMSEA=.061, (CI=.051 - .072). The modification indices indicated that four items could be deleted, which yielded a results with fit indices within the acceptable range. For the subtest community the initial results were  $\chi^2(35)=269.82$ ,  $p < .000$ , CFI=.826, TLI=.776, RMSEA=.088, (CI=.078 - .098). Based on the modification indices, one item was deleted and the fit indices were within acceptable range. For the final subtest Money the initial results were  $\chi^2(35)=178.74$ ,  $p < .0001$ , CFI=.892, TLI=.861, RMSEA=.069, (CI=.059 - .079). Based on modification indications one item was deleted and the fit indices were within the acceptable range.

|              | No items | Alpha | Chi-square | CFI  | TLI  | RMSEA |
|--------------|----------|-------|------------|------|------|-------|
| RD parent    | 10       | .87   | 167.40*    | .937 | .919 | .066  |
| RD skill     | 8        | .82   | 71.43*     | .958 | .941 | .054  |
| RD family    | 10       | .85   | 139.29*    | .939 | .921 | .059  |
| RD education | 9        | .84   | 110.42*    | .944 | .926 | .060  |
| RD peer      | 6        | .63   | 21.47*     | .963 | .938 | .040  |
| RD community | 9        | .76   | 99.03*     | .933 | .911 | .055  |
| RD money     | 9        | .79   | 107.13*    | .926 | .901 | .059  |

\* $p < .001$

Table 2: Confirmatory factor analyses with each of the subtests for the Resilience Doughnut, with the mean and standard deviation (N=867).

**Exploration of construct validity**

Table 3 presents the correlations between the subtests of the Resilience Doughnut and READ total score as well as its five factors. The correlations were all positive and significant in the moderate to strong range. The highest correlation was between RD Parents and the READ Family cohesion. The lowest correlation was between RD Peer and READ Structured style. However, RD Education and READ Structured style correlated in the high range.

| Subscales                | Parent | Skill | Family | Education | Peer  | Community | Money |
|--------------------------|--------|-------|--------|-----------|-------|-----------|-------|
| READ personal competence | .41**  | .51** | .32**  | .50**     | .23** | .41**     | .39** |
| READ social competence   | .30**  | .42** | .31**  | .38**     | .32** | .40**     | .27** |
| READ personal structure  | .41**  | .43** | .31**  | .48**     | .16** | .40**     | .44** |
| READ family cohesion     | .67**  | .39** | .51**  | .44**     | .21** | .44**     | .40** |
| READ social resources    | .47**  | .35** | .42**  | .42**     | .27** | .38**     | .27** |
| READ total               | .54**  | .51** | .44**  | .54**     | .28** | .49**     | .43** |

\*\*p<.001

Table 3: The correlations between the Resilience Doughnut subtests and the READ total and factor scores (N=867).

Table 4 presents the correlations between the Resilience Doughnut subtests and the SDQ factor scores. All correlations were significant, and negative for the SDQ factor scores Emotional symptoms, Conduct problems, Hyperactivity and Peer problems and positive for the factor Pro-social. The exception was the non-significant correlation between Peer and Hyperactivity.

Table 5 presents four multiple hierarchical linear regression analyses with four of the SDQ factors as dependent variables. The results indicate that the subtests RD Parents, RD Skills and RD Education were unique predictors of SDQ Emotional symptoms and that they explained 13% of the variance. For SDQ Conduct disorder 16% of the variance was explained by the unique predictors were RD Parents, RD Education. For SDQ Hyperactivity 21% was explained, and the negative unique predictors were RD Education, RD Money, and RD Parents. However, RD Peer was a positive predictor indicating that the

higher adolescents score themselves on the resilience peer subtest the higher they score themselves on levels of hyperactivity. For SDQ Peer problems 9% of the variance was explained by the predictors. The negative significant predictors were RD Parents, RD Peers and RD Education. However, RD Money was a positive unique significant predictor of levels of SDQ peer problems.

| Subscales              | Parent | Skill  | Family | Education | Peer   | Community | Money  |
|------------------------|--------|--------|--------|-----------|--------|-----------|--------|
| SDQ emotional symptoms | -.28** | -.30** | -.20** | -.30**    | .14**  | -.25**    | -.20** |
| SDQ conduct problems   | -.37** | -.17** | -.22** | -.32**    | -.07*  | -.20**    | -.22** |
| SDQ hyperactivity      | -.32** | -.28** | -.24** | -.40**    | -.06   | -.28**    | -.33** |
| SDQ peer problems      | -.23** | -.18** | -.16** | -.23**    | -.19** | -.19**    | -.08*  |
| SDQ pro-social         | .32**  | .30**  | .29**  | .34**     | .22**  | .32**     | .25**  |

\*p<05 \*\*p<.01

Table 4: The correlations between the Resilience Doughnut subtests and the SDQ factor scores (N=867).

|                       | SDQ emotion | SDQ conduct | SDQ hyper | SDQ peer |
|-----------------------|-------------|-------------|-----------|----------|
| Step 1 R <sup>2</sup> | .13***      | .16***      | .21***    | .09***   |
| RD parents            | -3.31***    | -6.73***    | -2.27*    | -3.63*** |
| RD skill              | -3.38***    | 1.15        | -1.20     | -.71     |
| RD family             | -.03        | -.33        | -.86      | .26      |
| RD education          | -2.76**     | -4.93***    | -6.34***  | -2.51*   |
| RD peer               | .17         | 1.86        | 3.83***   | -3.29*** |
| RD community          | -.58        | .74         | -.51      | -.90     |
| RD money              | -.54        | -1.54       | -4.92***  | 2.46*    |

\*p<05 \*\*p<.01 \*\*\*p<.001

Table 5: Multiple hierarchical linear regression analyses with the SDQ factors as dependent variables and the Resilience Doughnut subtests as predictors (N=867).

## Discussion

If personal resilience is the process of navigating and negotiating with social resources (RD) to increase personal and social competence (READ). It would therefore be the successful use of these resources, which would show a healthy coping response to adversity. That is, activating helpful resources (RD) would lead to a healthy response to difficulties rather than being overwhelmed by them (SDQ). Furthermore, working with the existing strong resources supports a solution focused approach of finding and doing more with what is working (Kelly, Bluestone-Miller, Mervis & Fuerst, 2012).

Since the Resilience Doughnut model represented the available resources in this study, the Resilience Doughnut tool needed to be assessed for validity and reliability before any correlations could be carried out. The results from the confirmatory factor analysis appeared to align with the theoretical concepts from the research on each of the seven contexts. Several items were deleted to achieve an acceptable fit as each of these items another referred to the same concept. One item was removed from the Community subscale as it did not add any value to the fit. The removal of 9 items therefore made the combined subscales 61 items for a confirmatory analysis showing an acceptable fit for the model. Internal consistency of the scales was then examined and provided evidence for an acceptable reliability of the scales for the sample with an Alpha coefficient between .63 and .87 for each of the factors. From these results it appears that the research constructs are well represented by the items. This result then enabled the second set of hypothesis of the model to be tested.

The first hypothesis suggests that a higher score in resource strengths as shown by the Resilience Doughnut would be associated with a higher score in personal and social competence as measured by the READ. The five subscales in the READ are; Personal competence (self-confidence, planning, hope, determination); Social resources (aware of supports and value of people); Social competence (communication and social skills); Family cohesion (positive family, supportive and common values); Personal structure (plan ahead and organization skills). The high correlation of each of the subscales of the READ and each of the contexts of the RD shows that strong positive connections in various contexts is related to stronger social and personal competence. Of interest was the separate subtest for parents and family in the RD. The items in the RD refer to specific characteristics of the relationship of the parents separate to other family members thereby giving a separate subtest. It would seem there is value of having a separate measure when there is high parental conflict or out of home care is in place allowing a measure to assess



the extended family cohesion. The high correlation of both RD parent and RD family with the READ family cohesion subscale confirms the validity of both these scales in measuring the positive family support available. The lowest correlation between RD peer and READ structured style, indicate that stronger peer relationships were not associated with stronger organizational skills, however the high correlation with the RD education and the READ structured style indicates a stronger connection with education was associated with stronger organizational skills. Thus from the correlations with the READ and the RD subtests it would seem that the hypotheses have been confirmed indicating that the higher the resource strengths, indicated by the RD subtests, the higher the level of personal and social competence experienced and vice versa.

The second hypothesis is that an increase in resource strengths would lead to lower difficulties experienced according to the SDQ. A significant negative correlation with the four difficulty subscales in the SDQ, with six of the seven contexts of the Resilience Doughnut was evident, again indicating that positive connections in various contexts are related to lower emotional and social problems and higher prosocial behaviours. The only subscale to not reach significance was the peer subscale with the hyperactivity subscale.

The subtest of hyperactivity is sensitive to inattentiveness and restlessness, which may not directly impact the relationship with peers. Of interest however is the strong correlation of hyperactivity with the RD education subscale which may indicate that symptoms of inattention and restlessness interfere with the youth's experience of education.

Further interesting findings were revealed in the multiple hierarchical analysis showing there were various subscales of the SDQ predicted by the RD subscales.

High RD Parent, Skills and Education factors were unique predictors of lower Emotional symptoms. High RD Parent and Education factors were unique predictors of lower conduct disorders, and high RD Education, Money and Parent factors were unique predictors of lower hyperactivity. The positive predictor of a high RD Peer factor with symptoms of hyperactivity is contrary to the correlation findings. However, with other factors taken into account the positive prediction may be explained by the distracting nature of friendships during adolescence with more friendships reported, the more distractible and restless a young person may be (Marsh, Allen, Ho, Porter & McFarland, 2006). Furthermore, some of the items for the RD peer factor refer to tensions experienced through conflict ("I have friends who say what they think and sometimes we fight"), and fitting in with the peer group ("I can change how I behave in my group so I can fit in"), which may lead to times of

inattentiveness and restlessness indicative of hyperactivity as measured by the SDQ.

Further analysis also showed that higher RD peer, parent and education subscales predicted lower RD peer problems, which again supported the hypothesis that the successful negotiation of resources led to social and personal competence. However, it was interesting to note that a high RD money subscale predicted higher RD peer problems. The RD money subscale refers to the management of money (“I can talk about how to save and spend money in my family”), earning through working (“I am earning money through doing extra chores or working”), spending (“I am happy with how I spend my money”), saving (“I can wait and save for things I would like to buy”) and attending to chores at home (“I am asked to contribute to chores around the house”). Of consideration, the youth in the sample who are in paid work (ages 15 years,) would be in the early stage of their paid working life and time away to work or do chores may interfere with social interaction with their peers.

Furthermore, the regression analysis shows that between two and four of the RD factors independently of each other, predict levels of emotional and behavioural symptoms. It has long been the hypothesis for the model (Worsley, 2012, 2015) that when three RD factors are strong and positive, the individual has greater levels of competence associated with resilience skills. This would suggest that the contexts are not independent dimensions of resilience. This study has not addressed the interactional nature of the external contexts on resilience thus further studies are recommended to test this hypothesis.

The results from this study enable a number of pathways of study to continue.

It would be of interest to examine the number and strength of the RD subscales which contribute to developing resilience. Understanding the number of protective contexts needed to develop resilience could lead to predictive and preemptive analysis giving rise to more tailored interventions in times of difficulties. Examination of each of the protective contexts and their relative strengths in developing resilience across cultures may show multiple pathways to resilience according to the available strengths in each culture. Studies as to the application of the model during the transitions of adult life stages (McDonald & Mair, 2010), such as parenting and aging may be useful in emphasizing the relative strengths needed to develop and maintain healthy functioning during these transitional stages.

Overall, the emphasis in the model of the interactions of intentional and positive relationships occurring in a number of different contexts, show that the person who is more connected is more resilient in the face of adversity. The studies on the merit of social capital (Bottrell, 2009; Cheung & Yue, 2013;

Parcel, Dufur & Zito, 2010; Sarracino, 2010) in coping with life are well supported by the Resilience Doughnut model. It might be advantageous to then use the Resilience Doughnut model to assess the strengths of social capital in mental health (McKenzie & Harpham, 2006), aging, trauma, natural disasters (Augustine, 2010; Pfefferbaum, Pfefferbaum & Norris, 2010; Terrior, 2006).

In conclusion it would seem that the Resilience Doughnut tool based on the model is a good fit representing the concepts from the literature and previous studies in resilience ecological factors. The linear hypotheses of higher resources leading to increased personal competence, and decreased emotional and social difficulties was well supported by this study of Australian youth. It would therefore be advantageous to explore this model in a number of contexts to determine the validity of the model across contexts and cultures, as well as ascertain the number and strength of the resources needed to build resilience at any one time.

## References

- Augustine, J. (2010). *The effects of individual, family, and community factors on adult resilience: A study on the tsunami survivors of 12/26/2004*. Unpublished Ph.D. dissertation: University of Denver.
- Ben-Arieh, A. (2005). Where are the children? Children's role in measuring and monitoring their well-being. *Social Indicators Research*, 74(3), 573–596. doi: 10.1007/s11205-004-4645-6
- Benard, B. (2004). *Resiliency. What we have learned*. San Francisco: Wested.
- Bottrell, D. (2009). Dealing with disadvantage: Resilience and the social capital of young people's networks. *Youth & Society*, 40(4), 476–501. doi: 10.1177/0044118X08327518
- Bronfenbrenner, U. (2005). Strengthening family systems (1988). [References] *Making human beings human: Bioecological perspectives on human development* (pp. 260–273). Thousand Oaks, CA: Sage Publications Ltd.
- Burgin, D. & Steck, B. (2009). Evaluation of resilience — Factors in the diagnostic-therapeutic interview with children. *Schweizer Archiv fur Neurologie und Psychiatrie*, 160(6), 257–264.
- Cheung, C. K. & Yue, X. D. (2013). Sustaining resilience through local connectedness among sojourn students. *Social Indicators Research*, 111(3), 785–800. doi: 10.1007/s11205-012-0034-8
- Domínguez, S. & Arford, T. (2010). It is all about who you know: Social capital and health in low-income communities. *Health Sociology Review*, 19(1), 114–129. doi: 10.5172/hesr.2010.19.1.114
- Durrant, M. (2016). Confessions of an unashamed Solution-Focused purist: What is (and isn't) Solution-Focused? *Journal of Solution-Focused Brief Therapy*, 2(1),

40–49.

- Fry, P. S. & Debats, D. L. (2010). Psychosocial resources as predictors of resilience and healthy longevity of older widows. [References] *New frontiers in resilient aging: Life-strengths and well-being in late life* (pp. 185–212). New York, NY: Cambridge University Press.
- Frydenberg, E. (2007). *The best of coping. Developing coping skills for adolescents. Facilitators guide*. ACER Press, South Melbourne.
- Fuller, McGraw, K. & Goodyear, M. (1998). *The mind of youth — Initial findings from the Resiliency Project*. Unpublished report for the Department of Education, Victoria. Department of Education. Melbourne.
- Gilgun, J. F., Klein, C. & Pranis, K. (2000). The significance of resources in models of risk. *Journal of Interpersonal Violence*, 15(6), 631–650. doi: 10.1177/088626000015006005
- Goodman, R. (1997). The Strength and Difficulties Questionnaire; A research note. *Journal of Child Psychology and Psychiatry*, 38, 581–586.
- Grotberg. (1995). *A guide to promoting resilience in children: Strengthening the human spirit. Early Childhood development: Practice and reflections*. Retrieved from <http://resilnet.uiuc.edu/library/grotb95b.html>
- Hawes, D. J. & Dadds, M. R. (2004). Australian data and psychometric properties of the Strengths and Difficulties Questionnaire. *Australian and New Zealand Journal of Psychiatry*, 38(8), 644–651. doi: 10.1111/j.1440-1614.2004.01427.x
- Hjemdal, O., Friborg, O., Stiles, T. C., Martinussen, M. & Rosenvinge, J. H. (2006). A new scale for adolescent resilience: Grasping the central protective resources behind healthy development. *Measurement and Evaluation in Counseling and Development*, 39, 8496.
- Kelly, M., Bluestone-Miller, R., Mervis, B. & Fuerst, R. (2012). The family and school partnership program: A framework for professional development. *Children & Schools*, 34, 249–252. doi: 10.1093/cs/cds031.
- Marsh, Allen, J. P., Ho, M., Porter, M. & McFarland, F. C. (2006). The changing nature of adolescent friendships longitudinal links with early adolescent ego development. *Journal of Early Adolescence*, 26(4), 414–431. doi: 10.1177/0272431606291942
- Marsh, H. W., Martin, A. J. & Hau, K. T. (2006). A multimethod perspective on self-concept research in educational psychology: A construct validity approach. In M. Eid & E. Diener (Eds.), *Handbook of multimethod measurement in psychology* (pp. 441–456). Washington, DC: American Psychological Association.
- Masten, A. S. & Coatsworth, J. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist*, 53(2), 205–220. doi: 10.1037/0003-066X.53.2.205
- Masten, A. S. & Wright, M. O. D. (2010). Resilience over the lifespan: Developmental perspectives on resistance, recovery, and transformation. [References] *Handbook of adult resilience* (pp. 213–237). New York, NY: Guilford Press.

- McDonald, S. & Mair, C. A. (2010). Social capital across the life course: Age and gendered patterns of network resources. *Sociological Forum*, 25(2), 335–359. doi: 10.1111/j.1573-7861.2010.01179.x
- McGraw, K., Moore, S., Fuller, A. & Bates, G. (2008). Family, peer and school connectedness in final year secondary school students. *Australian Psychologist*, 43(March), 27–37. doi: 10.1080/00050060701668637
- McKenzie, K. & Harpham, T. (2006). *Social capital and mental health*. London, England: Jessica Kingsley Publishers.
- Parcel, T. L., Dufur, M. J. & Zito, R. C. (2010). Capital at home and at school: A review and synthesis. *Journal of Marriage and Family*, 72(4), 828–846. doi: 10.1111/j.1741-3737.2010.00733.x
- Pfefferbaum, B., Pfefferbaum, R. L. & Norris, F. H. (2010). Community resilience and wellness for the children exposed to Hurricane Katrina. In R. P. Kilmer, V. Gil-Rivas, R. G. Tedeschi & L. G. Calhoun (Eds.), *Helping families and communities recover from disaster: Lessons learned from hurricane Katrina and its aftermath* (pp. 265–285). Washington, DC: American Psychological Association.
- Riley, J. R. & Masten, A. S. (2005). Resilience in context. In R. D. Peters, B. Leadbeater & R. J. McMahon (Eds.), *Resilience in children, families, and communities: Linking context to practice and policy* (pp. 13–25). New York, NY: Kluwer Academic/Plenum Publishers.
- Rutter, M. (2008). Multiple meanings of a developmental perspective on psychopathology. *Hellenic Journal of Psychology*, 5(3), 281–323.
- Rutter, M. (2006). The promotion of resilience in the face of adversity. In A. Clarke-Stewart & J. Dunn (Eds.), *Families count: Effects on child and adolescent development* (pp. 26–52). New York: Cambridge University Press.
- Sarracino, F. (2010). Social capital and subjective well-being trends: Comparing 11 western European countries. *The Journal of Socio-Economics*, 39(4), 482–517. doi: 10.1016/j.socec.2009.10.010
- Sharkey, J. D., You, S. & Schnoebelen, K. (2008). Relations among school assets, individual resilience, and student engagement for youth grouped by level of family functioning. *Psychology in the Schools*, 45(5), 402–418. doi: 10.1002/pits.20305
- Silva, T. B., Osorio, F. L. & Loureiro, S. R. (2015). SDQ: discriminative validity and diagnostic potential. *Frontiers in Psychology*, 6, 811. doi: 10.3389/fpsyg.2015.00811
- Soest, T., Mossige, S., Stefansen, K. & Hjemdal, O. (2010). A validation study of the Resilience Scale for Adolescents (READ). *Journal of Psychopathology and Behavioral Assessment*, 32(2), 215–225. doi: 10.1007/s10862-009-9149-x
- Steinhardt, M. & Dolbier, C. (2008). Evaluation of a resilience intervention to enhance coping strategies and protective factors and decrease symptomatology. *Journal of American College Health*, 56(4), 445–453. doi: 10.3200/JACH.56.4.445-454
- Terrion, J. L. (2006). Building social capital in vulnerable families: Success markers of a school-based intervention program. *Youth & Society*, 38(2), 155–176. doi:

10.1177/0044118X05282765

- Tol, W. A., Jordans, M. D., Reis, R. & de Jong, J. (2009). Ecological resilience: Working with child-related psychosocial resources in war-affected communities. . In D. Brom, R. Pat-Horenczyk & J. D. Ford (Eds.), *Treating traumatized children: Risk, resilience and recovery* (pp. 164–182). New York, NY: Routledge/Taylor & Francis Group.
- Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work, 38*(2), 218-235. doi: 10.1093/bjsw/bcl343
- Ungar, M., Brown, M., Liebenberg, L., Cheung, M. & Levine, K. (2008). Distinguishing differences in pathways to resilience among Canadian youth. *Canadian Journal of Community Mental Health, 27*(1), 1–13.
- Ungar, M. & Lerner, R. M. (2008). Introduction to a special issue of research in human development: Resilience and positive development across the life span: A view of the issues. *Research in Human Development, 5*(3), 135–138. doi: 10.1080/15427600802273961
- Ungar, M. & Liebenberg, L. (2009). Cross-cultural consultation leading to the development of a valid measure of youth resilience: The international resilience project. *Studia Psychologica, 51*(2-3), 259–268.
- Werner, E. E. & Smith, R. S. (2001). *Journeys from childhood to the midlife: Risk, resilience and recovery*. London: Cornell University Press.
- Werner, E. E. & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Cornell University Press..
- Windle, G. & Woods, R. T. (2004). Variations in subjective wellbeing: the mediating role of a psychological resource. *Ageing and Society, 24*(4), 583-602. doi: 10.1017/s0144686x04002107
- Worsley, L. (2011). *The Resilience Doughnut. The secret of strong kids*. Sydney: Griffin Press.
- Worsley. (2012). *The Resilience Doughnut. The secret of strong adults*. Griffin Press.
- Worsley. (2014a). Building resilience in three Australian high schools, Using the Resilience Doughnut framework. In S. Prince-Embury & D. Saklofske (Eds.), *Resilience interventions for youth in diverse populations* (pp. 217–257). New York, Heidelberg: Springer.
- Worsley. (2014b). *The Resilience Doughnut. The Resilience Report*, Retrieved 2015, from <http://www.resiliencereport.com/>
- Worsley. (2015). The Resilience Doughnut; combining strengths to thrive. In M. C. P. S. Holden (Ed.), *Victim victorious: From fire to phoenix* (pp. 67–88). Bond University, Robina: Nova Science Publishers.
- Zautra, A. J., Arewasikporn, A. & Davis, M. C. (2010). Resilience: Promoting well-being through recovery, sustainability, and growth. *Research in Human Development, 7*(3), 221-238. doi: 10.1080/15427609.2010.504431

### **About the authors:**

Lyn Worsley is a Clinical Psychologist with a background in nursing, teaching, and youth work. She is Director of the Resilience Centre in Sydney, Australia, which has a reputation for innovative Solution-Focused approaches to client change through individual and group therapies for over 20 years. At the Resilience Centre, Lyn supervises specialist psychologists, and coordinates community seminars, training workshops, and resilience groups for people of all ages. Lyn is the author of *The Resilience Doughnut*, a pioneering model showing the strong contexts where resilience is enhanced, both during development and throughout adulthood. The Resilience Doughnut has become a foundational ecological model of resilience used by practitioners all around Australia and is quickly spreading to other countries including, Singapore, Canada and the UK.

Email: [lyn@theresiliencecentre.com.au](mailto:lyn@theresiliencecentre.com.au)

Odin Hjemdal is professor of clinical adult psychology and quantitative methods and statistics in the Department of Psychology at the Norwegian University of Science and Technology, Trondheim, Norway. His research is related to resilience among adults and adolescents, and particularly measuring protective factors. Developing research based direct measures of protective factors that captures essential protective resources is important because it may contribute to clarifying the relation between risk, vulnerability, protection and mental health. In addition to resilience, his research spans mental health, prevention of psychological disorders like anxiety and depression, psychological components related to somatic health in e.g. heart disease and cancer, cognitive therapy and meta-cognitive therapy. He is a cognitive and a metacognitive therapist and a supervisor in both therapies.

Email: [odin.hjemdal@ntnu.no](mailto:odin.hjemdal@ntnu.no)

## Evaluating the effectiveness of a resilience program for children and young people in a private Australian psychology clinic<sup>1</sup>

Kaitlyn Miller<sup>2</sup>, Lyn Worsley<sup>3</sup>, Tanya Hanstock<sup>4</sup> and Megan Valentine<sup>4</sup>

2. John Hunter Children's Hospital 3. The Resilience Centre, Epping 4. The University of Newcastle

There is increasing research into resilience enhancing intervention programs in young people. A number of international resilience-based group programs exist; however, few are within Australia. Two Australian resilience programs are the Linked-Up (13-16 year-olds) and Connect-3 (8-12 year-olds) programs. They are Solution-Focused programs based on the Resilience Doughnut model. The current study assessed the effectiveness of these two programs by comparing pre- and post-measures of resilience and adversities. Participants were aged between 8-17 years. There were 70 participants in total, 40 males (57%) and 30 females (43%). Results show that the Connect-3 program built personal competency and reduced total difficulties within a non-clinical population. The Linked-Up group showed no significant change in scores for pre-intervention to post-intervention. Future research should aim to explore the effectiveness of the resilience programs within clinical populations or with young people who have increased risk of adversity. Future research should also consider how resilience could be enhanced in older-adolescent populations.

Resilience is an important area of study because coping with stress, change and adversity is a facet of everyday life. This is particularly true for children and adolescents, who experience multiple biological, social and psychological changes during this developmental phase (Barrett et al., 2014). It is generally accepted that resilience is an individual's ability to bounce back from adver-

1. The research reported in this paper was completed by the first author in partial fulfillment of the requirements for the degree of Master of Clinical Psychology at the University of Newcastle. A version of this paper was presented to the Pathways to Resilience Conference in Halifax, Canada in June 2015.



sity (Ungar, 2015; Prince-Embury, 2014; Werner & Smith, 2001). This ability is influenced by the complex interaction between protective factors, such as positive social relationships, economic stability, or adaptive coping skills, and risk factors, such as vulnerability to mental health problems, poor attachment or other adversities (Ungar et al., 2015; Werner & Smith, 1992; 2001). Ungar et al. (2015) emphasise that protective factors are not just personal characteristics or qualities of the individual, but also include the availability of community resources (e.g., social supports, and formal service providers) as well as the individual's capacity to access and utilise these resources.

### **Defining Resilience**

There is still no single agreed definition of resilience despite consensus that resilience is developed through both internal resources and external factors. Early definitions of resilience were primarily focused on overcoming adversity, such as Grotberg (1995), who stated, "resilience is the universal capacity which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity" (p.3). Masten and Powell (2003) stated, "Resilience refers to patterns of positive adaptation in the context of significant risk and adversity" (p. 4).

Over time, definitions have developed to be more comprehensive and complex, to include not just the individual, but also the community within which they live. Ungar, Brown, Liebenberg, Cheung and Levine (2008) define resilience as "the capacity of individuals to navigate their physical and social ecologies to provide resources, as well as their access to families and communities who can culturally navigate for them" (p. 168). In this definition Unger et al. (2008) identify that resilience is more than just having, or not having resources, but it is also the capacity to know how to use these resources to be resilient. This definition also identifies that individuals require support from their families and communities to assist in understanding and using these resources.

Ungar (2015) describes the development of resilience as a complex, multidimensional process, where the ability to withstand adversity is not simply dependent on the outweighing of protective factors over risk factors, but rather, "resilience is predicted by both the capacity of individuals and the capacity of their social and physical ecologies to facilitate their coping in culturally meaningful ways." (p. 4)

Overall, it is evident that throughout the research there is a consensus that resilience is developed through both internal resources such as personal characteristics and skills, as well as external factors, such as environmental,

social and educational factors. Luthar, Cicchetti and Becker (2000) clarified this further, by stating that the personal qualities can be referred to as “resiliency”, whereas “resilience” is the developmental process that occurs through the interaction of the internal qualities and the external factors.

## Theories of Resilience

There are many theories about what formulates the protective factors of resilience. Grotberg (1995) categorised them into three main areas ‘I HAVE, I AM, I CAN’. I HAVE are the external supports that promote resilience (e.g., I have trusting relationships); I HAVE factors are foundational to the subsequent categories. I AM is the child’s personal strengths and characteristics (e.g., I am loveable). The I CAN is the child’s interpersonal and social skills (e.g., I can communicate and problem solve).

Other researchers have provided more specific categories, such as community, school, family and individual/peers (Fuller, 1998) and social competence, problem solving, autonomy and sense of purpose (Benard, 2004). Ungar (2008) redefined the protective factors and personal qualities as ‘tensions’. He hypothesised that people need to balance these tensions in order to enhance their resilience, and having too much or too little of these resources removes the tensions that are important to developing resilience. Overall, there appears to be a consensus in the research that resilience is developed through both internal resources, such as personal characteristics and skills, and external factors, such as environmental, social and educational factors.

## Intervention Programs for Non-Clinical Populations

Understanding that resilience is a process influenced by risk and protective factors, more recent research has been interested in how resilience can be developed or enhanced. Seligman (2002) suggests that resiliency can be enhanced with Positive Psychology through utilising a strength-based approach to build people’s capacity, rather than correcting their difficulties. There is considerable research into treatment programs that aim to enhance resilience, and evidence suggests that prevention programs are important in assisting people to overcome difficult circumstances and prevent mental health problems (Barrett et al., 2014). There are a number of international resilience-based programs, such as the Penn Resiliency Program (Gillham et al., 2007); however, there are only two resilience programs that have been evaluated in Australia. The FRIENDS program (Barrett, 2012) and the Resilience Doughnut model (Worsley, 2006) aim to enhance resilience in non-clinical

ical child and adolescent populations.

### ***FRIENDS program***

The FRIENDS program (Barrett, 2012) is the most widely researched resilience-enhancing program in Australia and was first developed and evaluated by Barrett and Turner (2001). The aim of the FRIENDS program (Barrett, 2012) is to develop social and emotional skills in children and adolescents in order to promote resilience and prevent anxiety and depression (Barrett et al., 2014). The program is based on the theoretical framework of Cognitive-Behavioural Theory (CBT) and Positive Psychology (Barrett et al., 2014). It uses the acronym of FRIENDS to form the basis of the program, for example, the F stands for 'feelings' and focuses on developing social and emotional skills.

The FRIENDS program (Barrett, 2012) has been evaluated several times as a universal program, using pre-intervention, post-intervention and follow-up data (Lock & Barrett, 2003; Barrett, Lock & Farrell, 2005). The results demonstrated that the program was successful in reducing anxiety and increasing coping skills, with the strongest effects noticed in the group of children aged between 9 and 10 years old compared to the group of adolescents aged between 14 and 16 years-old. Lock and Barrett (2003) used these findings to suggest that earlier intervention could be more beneficial than later intervention.

A follow-up study of Lock and Barrett's (2003) findings was completed to assess the effects of the program at 24 and 36-month intervals (Barrett, Farrell, Ollendick & Dadds, 2006). This study found that the reductions in anxiety were maintained for the younger age group (9-10 years) of students who were in the treatment condition, and not in the aged-matched control group. They also reported a gender effect, with girls in the intervention group scoring lower on anxiety after the intervention than girls in the control group, although this difference was not maintained at the 36-month follow-up. The authors suggest that this finding supports the previous study's hypothesis that earlier intervention, specifically during ages 9-10 years, is ideal for long-term benefits.

Whilst these research findings are positive, an important consideration of the FRIENDS program is whether it actually focuses on developing resilience or whether it focuses more on the management of anxiety. The studies discussed primarily define themselves as a CBT interventions to reduce anxiety, rather than as a program designed to develop resilience. This is particularly evidenced by the authors not using any known measures of resilience, such

as the Resilience Scale for Adolescents (READ; Hjemdal, Friborg, Stiles, Martinussen & Resenvinge, 2006) to measure the effect of the FRIENDS intervention on developing the factors that build resilience.

### ***The Resilience Doughnut***

The Resilience Doughnut program was developed by Worsley (2006) and is based in the theoretical framework of Solutions-Focused Theory (SFT) and Positive Psychology. As the name suggests, the program is based around the concept of a doughnut, where inside the doughnut represents the internal strengths of the individual, and the outside of the doughnut represents seven protective factors they may have, such as social and environmental factors (see Figure 1). The internal strengths are based on the work of Grotberg (1995), while the protective factors are rooted in the theoretical research by Werner and Smith (2001), Fuller (1998) and Ungar (2008) and are 'Parent', 'Skill', 'Family and Identity', 'Education', 'Peer', 'Community' and 'Money'. Worsley (2014) suggests that the process of resilience is built when the external factors feed into the internal strengths of a child. She states that the Resilience Doughnut is not about teaching children to be resilient, but rather it is about teaching families and communities to have relationship skills that build

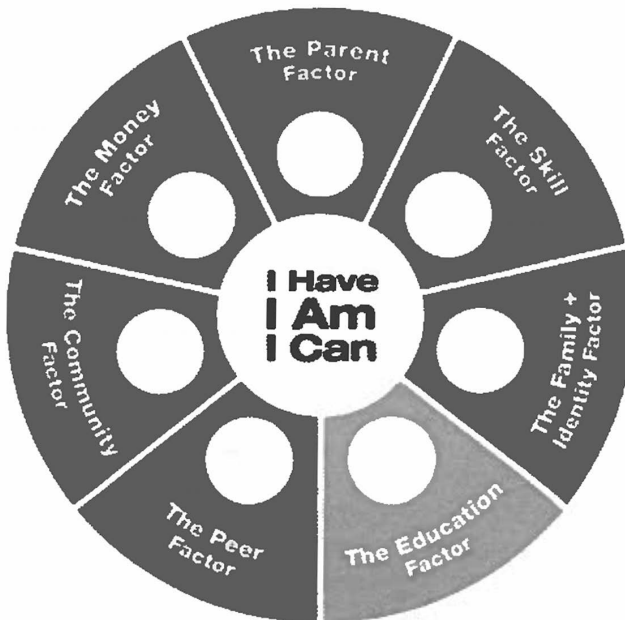


Figure 1. The Resilience Doughnut model (Worsley, 2006)

resilience in children. This process occurs through helping children and their families gain more self-awareness and social skills, as well as developing creative ways to strengthen their external protective factors (Worsley, 2008).

Worsley (2014) suggests that not all seven factors need to be present to build resilience but hypothesises that three factors are sufficient to enhance wellbeing. Through strengthening three factors, Worsley (2014) hypothesises that the rest of the factors will be strengthened too. This is based on the principles of SFT, which suggests that focusing on strengths, rather than problems, will elicit positive change and promote resiliency (Seligman, 2002). Similar to the FRIENDS program, the Resilience Doughnut framework teaches students about optimistic thinking and also provides parent education sessions on the model.

The Resilience Doughnut (Worsley, 2006) has not been researched as frequently as the FRIENDS program; however, three case studies conducted by Worsley (2014) demonstrate a number of positive outcomes for the model. Three schools were selected to utilise the Doughnut model. The first and second case study used students aged between 13-15 years-old to implement the program, and the third case study used students aged between 12-17 years-old. Specific staff members were trained in the Resilience Doughnut model, which they implemented with their students using an online tool. The online tool assisted the students in identifying their three strongest protective factors. The students then had to develop a project linking their three strengths. For example, a student's strengths might be Parent Factor, Skill Factor (skill being football) and Community Factor. This child's project might involve planning a football match in the local park and inviting his parents to participate.

Pre- and post-measures of anxiety, depression and resilience were taken for each case study, including longitudinal follow up at 12 and 24 months. The measure differed across each of the case studies, but included the Multidimensional Anxiety Scale for Children (MASC-10; March, 1997), the Child Depression Index (CDI-10; Kovacs, 2003), the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), the Child, Youth Resilience Measure (CYRM; Ungar, 2008), the Resilience Scale (RS-14; Wagnild & Young, 1993) and the Resilience Scale for Adolescents (READ; Hjemdal et al., 2006). Post-intervention results showed that children with high and medium anxiety, based on the MASC-10, increased their resilience scores on the resilience measures over time. Worsley (2014) suggests that these results demonstrate that the Doughnut can be used successfully to build resilience in adolescents.

Further research is needed to develop the empirical evidence of the Resilience Doughnut model. Specifically, implementing the program over several sessions, rather than one session to give participants extra time to capital-

ise on the specific resources around them (Luthar & Cicchetti, 2000). Also, implementing the Doughnut program with both primary school students and high school students and comparing their scores of resilience. This may build on Barrett et al. (2006) suggestion that programs implemented at an earlier age are more effective at reducing symptoms of anxiety and/or depression and improving resilience.

## **Aims and Hypotheses**

The current study builds on Worsley (2014) research by evaluating two programs based on the Resilience Doughnut (2006) model. The Connect-3 (8-12 year-olds) and Linked-up (13-16 year-olds) programs are interactive 6-week group programs designed to help young people develop their personal competency, improve their social interactions and develop resilient thinking skills (Worsley, 2012a & Worsley, 2012b). This research aims to assess the effectiveness of the two programs by measuring the change from pre-intervention to post-intervention for participants, using the Resilience Scale for Adolescents (READ; Hjemdal et al., 2006) and the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997).

It was hypothesised that there would be a significant improvement in the resilience measure scores and a decrease in difficulties scores at post-intervention. Specifically, it was hypothesised that participants would increase their scores on all subscales of the READ and decrease their scores on the subscales of the SDQ, with the exception of the Prosocial scale, which would increase. Secondly, it was hypothesised that the Connect-3 group will have a greater decrease in their difficulty scores and increase in the resilience scores compared to the Linked-Up population, based on Barrett et al. (2006) findings. Finally, it was hypothesised that the female participants would have a greater reduction in their difficulties scores and increase in their resilience scores compared to male participants, again based on Barret et al. (2006) results.

## **Method<sup>4</sup>**

### ***Participants***

Participants were children and adolescents aged between 8-17 years who were enrolled in either the Connect-3 or Linked-Up program. There were 70

---

4. Ethics approval for this study was obtained through the University of Newcastle Human Research Ethics Committee (reference no. H-2015-0152).

participants in total; 40 males (57%) and 30 females (43%), with a mean age of 10.43 years ( $SD=2.74$ ). There were 48 participants (69%) in the Connect-3 group (60% males, 40% females) and 22 participants (31%) in the Linked-Up group (50% males and females).

The participants parent's completed a consent form with their child, which provided permission for their child's information to be collected, de-identified and used for the research project. Participants who did not give consent to participate in the research were still able to complete the resilience program.

The programs were completed at The Resilience Centre, Sydney, within a high socio-economic suburb as indicated by the Socio Economic Indexes for Areas (SEIFA). The SEIFA is a range of indices created by the Australian Bureau of Statistics (ABS) to analyse the socio-economic status of a population. The Epping-North Epping Statistical Area 2 (SA2) ranks in the highest decile for three of the four SEIFA measures, indicating that it is a highly advantaged and highly educated population (ABS, 2013). More specific demographic details were unavailable for the participants, however, participants generally came from financially resourced families, as they were required to pay \$350 to participate in the program. Furthermore, as part of the program, parents of the participants were invited to attend parent-information sessions to encourage them to engage with what their child was learning. There is no data available for parent attendance at these sessions.

### ***Procedure***

Participants were recruited in several ways, most commonly through self-referral to the program. The resilience programs have a strong reputation in the local geographic area, and therefore, many referrals come from recommendations by previous participants. Other referral sources include general practitioners, school counsellors or psychologists who have knowledge of the program, and usually refer because the young person has difficulties with anxiety. Specific details of how many participants were referred from each source were unavailable for this research.

The group programs ran with approximately 6-10 participants in each group. If a participant was unable to attend any of the six sessions, they were offered an individual catch-up session with the provisional psychologist who was co-facilitating the program.

The Linked-Up and Connect-3 programs each ran over a 6-week period for 1.5-hour sessions, per-week. The programs had identical structure, using different examples and worksheets to tailor the concepts of the Resilience

Doughnut for the two developmental age groups. The programs were delivered by a psychologist and a provisional psychologist who had completed The Resilience Doughnut accredited training (Worsley, 2008). The facilitators followed a structure outlined by the program manuals, which is summarised in Table 1. Additionally, a parent information session was completed following the first session so parents and other family or community members could become engaged in what their child was doing within the program. After each other session, a parent letter was provided, detailing session content and how the strategies discussed could be implemented and developed at home or school. No data is available on overall student attendance at the 6 sessions or parent's attendance during the first week.

| Session | Description of the program           |
|---------|--------------------------------------|
| Week 1  | Introducing the Resilience Doughnut  |
| Week 2  | Identifying young person's strengths |
| Week 3  | Learning optimistic thinking         |
| Week 4  | Learning empathy and social skills   |
| Week 5  | Reporting on their kindness project  |
| Week 6  | Noticing change                      |

Table 1. Overview of the Connect-3 and Linked-Up programs

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) and the Resilience Scale for Adolescents (READ; Hjemdal, et al., 2006) were administered to students 1-week prior to the program commencing and repeated following the conclusion of the sixth session. Most participants completed the questionnaires via a computer, but due to some technical complications, six participants were required to complete the questionnaire using paper and pencil and results entered into the database manually.

### **Measures**

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). The SDQ is a brief behavioural screening questionnaire for people aged 3-16 years. It contains 25 items, divided into 5 subscales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and pro-social behaviour.

For this study, the SDQ was used as a measure of participant's risk factors



or adversities. Higher scores on each of the subscales indicate higher level of emotional symptoms, conduct problems, hyperactivity, peer problems and total difficulties, with the exception of the prosocial scale. As the prosocial scale is a measure of social competency, higher scores indicate a higher level of social resilience. The SDQ subscale scores are divided into four descriptive categories, based on the clinical cut-off points for the subscales. The descriptive categories range from 'close to average', indicating difficulties/prosocial score within a normal range through to 'very high (very low)', indicating a much higher than average score for difficulties (or much lower prosocial score). The SDQ has previously demonstrated good internal consistency, with a Cronbach  $\alpha$  of .93 (Goodman, 2001). For the current study the SDQ had moderate-weak internal consistency, with alpha coefficients ranging between .43 to .65 at pre-intervention to .43 to .82 at post-intervention (See Table 2). The validity of the SDQ is well established (Goodman, Ford, Simmons, Gatward & Meltzer, 2000).

|                      |                     | Cronbach alpha |      |
|----------------------|---------------------|----------------|------|
|                      |                     | Pre            | Post |
| <b>READ Subscale</b> | Personal Competency | .78            | .83  |
|                      | Social Competency   | .75            | .74  |
|                      | Structured Style    | .58            | .43  |
|                      | Social Resources    | .78            | .69  |
|                      | Family Cohesion     | .83            | .82  |
| <b>SDQ Subscale</b>  | Emotional Problems  | .61            | .82  |
|                      | Conduct Problems    | .50            | .51  |
|                      | Hyperactivity       | .58            | .50  |
|                      | Peer problems       | .43            | .43  |
|                      | Prosocial behaviour | .65            | .65  |
|                      | Total difficulties  | .49            | .64  |

Table 2. Reliability of the READ and SDQ subscales for pre and post (Cronbach alpha)

The Resilience Scale for Adolescents (READ; Hjemdal et al., 2006). The READ (Hjemdal et al., 2006) is a 28-item questionnaire that also consists of five subscales: personal competence, social competence, structured style, awareness of social resources, and family cohesion. The READ was used as a measure of

resilience in this study. It does not have recommended clinical cut-offs points, however, higher scores on each of the subscales indicate higher levels of resilience. The READ has previously demonstrated very strong internal consistency with Cronbach  $\alpha$  of .94 (Hjemdal et al., 2006). For the current study, the READ demonstrated adequate internal consistency, with alpha coefficients ranging between .58 to .83 at pre-intervention and .43 to .83 at post-intervention (See Table 2). The READ is considered to be a valid measure of resilience (von Soest, Mossige, Stefansen & Hjemdal, 2009).

### ***Statistical Analyses***

Statistical analyses were conducted using IBM SPSS Statistics for Windows (version 21.0; SPSS, Chicago, IL, USA) and all statistical tests used a type I error of  $\alpha=.05$ . Cronbach alpha coefficients were calculated for both the READ and SDQ, at both time points to determine the internal consistency of the subscales for these students.

Linear mixed models were created for all subscales of SDQ (total difficulties, emotion symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour) and READ (personal competence, social competence, structured style, awareness of resources and family cohesion) to compare baseline to post-treatment for students in each of the Connect-3 and Linked-Up groups separately.

A mixed models approach to analysing repeated measures data was used as it analyses on an intention to treat basis and there was incomplete data from participants for pre-intervention to post-intervention. The current study only had 29 data points available for post-intervention analysis. Mixed models analysis ensured all participants were included in the analysis and allowed inherent adjustments for baseline scores. Another advantage of using a mixed models approach is that the optimal covariance matrix is selected, resulting "in more appropriate estimates of the effect of treatment and their standard errors" (Brown & Prescott, 2006: p. 3). Model choice was based on comparison of two covariance patterns (Compound Symmetry and Unstructured/General) and selection of the covariance matrix with the best fit was indicated by the lowest Akaike's Information Criteria (AIC) and Schwartz's Bayesian Criterion (BIC) values. Compound Symmetry Matrix was most appropriate model for all subscales. Cohen's  $d$  effect size was calculated for each of the variables using the pooled standard deviation from the residual covariance matrix (Dunst & Hamby, 2012).

Further models were used to examine for any difference in gender for each of the two age groups (Connect-3 and Linked-Up). Correlation between

the READ and SDQ subscales was examined using Spearman's rho due to the relatively small number of students and non-normality of the distributions of the subscales.

## Results

### Main findings from baseline to post-intervention

Results for the Connect-3 (N=50) group on the SDQ showed a significant reduction in mean scores of 2.11 points from pre-intervention to post-intervention for Total Difficulties  $F(1,32)=4.60, p=.04, d=0.37$  (see Table 3).

| SDQ Connect-3       |              |              |            |              |             |                  |
|---------------------|--------------|--------------|------------|--------------|-------------|------------------|
|                     | Pre M (SE)   | Post M (SE)  | Difference | Significance | CI (95%)    | Cohen's <i>d</i> |
| Total difficulties  | 17.71 (0.81) | 15.60 (1.05) | -2.11      | .04*         | 0.11, 4.11  | 0.37             |
| Emotional problems  | 4.90 (0.36)  | 4.05 (0.46)  | -0.84      | .06          | -0.02, 1.71 | 0.33             |
| Conduct problems    | 3.37 (0.26)  | 3.20 (0.35)  | -0.17      | .63          | -0.87, 0.53 | 0.09             |
| Hyperactivity       | 5.85 (0.29)  | 5.04 (0.40)  | -0.82      | .06          | -1.68, 0.04 | 0.40             |
| Peer problems       | 3.59 (0.32)  | 3.35 (0.41)  | -0.24      | .52          | -1.00, 0.52 | 0.11             |
| Prosocial behaviour | 7.74 (0.25)  | 8.02 (0.33)  | 0.28       | .40          | -0.39, 0.95 | 0.16             |

Table 3. Linear Mixed Model Estimated Marginal Means (M), Significance (p) and Effect Size (d) for the Connect-3 group (n=48) on the SDQ measure.

| READ Connect-3      |              |              |            |              |             |                  |
|---------------------|--------------|--------------|------------|--------------|-------------|------------------|
|                     | Pre M (SE)   | Post M (SE)  | Difference | Significance | CI (95%)    | Cohen's <i>d</i> |
| Personal competency | 19.79 (0.81) | 22.44 (1.01) | 2.65       | .01*         | 0.66, 4.64  | 0.49             |
| Social competency   | 14.47 (0.54) | 15.10 (0.65) | 0.63       | .29          | -0.56, 1.82 | 0.17             |
| Structured style    | 10.40 (0.43) | 10.84 (0.56) | 0.44       | .45          | -0.74, 1.62 | 0.15             |
| Social resources    | 16.47 (0.49) | 16.49 (0.58) | 0.02       | .97          | -0.96, 1.00 | 0.01             |
| Family cohesion     | 19.29 (0.58) | 19.44 (0.73) | 0.15       | .84          | -1.34, 1.64 | 0.04             |

Table 4. Linear Mixed Model Estimated Marginal Means (M), Significance (p) and Effect Size (d) for the Connect-3 group (n=44) on the READ measure.

Additionally, differences in scores on the Emotional Problems and Hyperactivity subscale were approaching significance  $F(1,33)=3.92, p=.06, d=0.33$  and  $F(1,37)=3.70, p=.06, d=0.40$ , respectively. No other subscales of the SDQ

showed a significant change from pre to post-intervention for the Connect-3 group. On the READ measure, results for the Connect-3 group showed a significant increase in mean scores by 2.65 points on the subscale of Personal Competency from pre-intervention to post-intervention  $F(1,36)=7.31, p=.01, d=0.49$  ( See Table 4). No other subscales on the READ were significant for the Connect-3 group.

The results for the Linked-Up (N=22) group showed no significant change in scores for pre-intervention to post-intervention for either the SDQ or the READ (see Table 5 & 6). However, the subscale of Prosocial Behaviour on the SDQ was approaching significance  $F(1,34)=3.62, p=.07, d=0.62$ . There was an apparent increase in mean scores of 1.09 points from pre-intervention to post-intervention (See Table 5).

| SDQ Linked-Up       |              |              |            |              |             |                  |
|---------------------|--------------|--------------|------------|--------------|-------------|------------------|
|                     | Pre M (SE)   | Post M (SE)  | Difference | Significance | CI (95%)    | Cohen's <i>d</i> |
| Total difficulties  | 18.59 (1.21) | 15.60 (1.05) | -2.11      | .04*         | 0.11, 4.11  | 0.37             |
| Emotional problems  | 5.59 (0.54)  | 4.05 (0.46)  | -0.84      | .06          | -0.02, 1.71 | 0.33             |
| Conduct problems    | 3.32 (0.39)  | 3.20 (0.35)  | -0.17      | .63          | -0.87, 0.53 | 0.09             |
| Hyperactivity       | 5.27 (0.43)  | 5.04 (0.40)  | -0.82      | .06          | -1.68, 0.04 | 0.40             |
| Peer problems       | 4.41 (0.48)  | 3.35 (0.41)  | -0.24      | .52          | -1.00, 0.52 | 0.11             |
| Prosocial behaviour | 7.23 (0.37)  | 8.02 (0.33)  | 0.28       | .40          | -0.39, 0.95 | 0.16             |

Table 5: Linear Mixed Model Estimated Marginal Means (M), Significance (p) and Effect Size (d) for the Linked-Up group (n=22) on the SDQ measure.

| READ Linked-Up      |              |              |            |              |             |                  |
|---------------------|--------------|--------------|------------|--------------|-------------|------------------|
|                     | Pre M (SE)   | Post M (SE)  | Difference | Significance | CI (95%)    | Cohen's <i>d</i> |
| Personal competency | 17.72 (1.15) | 17.14 (1.79) | -0.59      | .74          | -2.91, 4.09 | 0.11             |
| Social competency   | 12.50 (0.77) | 12.49 (1.13) | -0.15      | .99          | -2.09, 2.12 | 0.04             |
| Structured style    | 8.96 (0.61)  | 9.19 (1.00)  | 0.23       | .82          | -1.83, 2.30 | 0.08             |
| Social resources    | 14.91 (0.70) | 14.36 (0.98) | -0.55      | .52          | -2.28, 1.18 | 0.17             |
| Family cohesion     | 16.36 (0.82) | 15.17 (1.30) | -1.19      | .36          | -3.81, 1.42 | 0.31             |

Table 6: Linear Mixed Model Estimated Marginal Means (M), Significance (p) and Effect Size (d) for the Linked-Up group (n=22) on the READ measure.

| Spearman's rho    | Personal competency     | Emotional problems      |                 |    |                  |               |               |                     |                    |    |        |    |         |
|-------------------|-------------------------|-------------------------|-----------------|----|------------------|---------------|---------------|---------------------|--------------------|----|--------|----|---------|
|                   |                         | Correlation coefficient | Sig. (2-tailed) | N  | Conduct problems | Hyperactivity | Peer problems | Prosocial behaviour | Total difficulties |    |        |    |         |
| Social competency | Correlation coefficient |                         | -.476**         |    | -.182            |               | -.005         |                     | -.198              |    | .307** |    | -.354** |
|                   |                         | Sig. (2-tailed)         | .000            | 64 | .150             | 64            | .968          | 64                  | .116               | 64 | .014   | 64 | .004    |
| Structured style  | Correlation coefficient |                         | -.197           |    | -.139            |               | .301*         |                     | -.326**            |    | .393** |    | -.146   |
|                   |                         | Sig. (2-tailed)         | .118            | 64 | .275             | 64            | .016          | 64                  | .009               | 64 | .001   | 64 | .251    |
| Social resources  | Correlation coefficient |                         | -.327**         |    | -.316*           |               | -.208         |                     | -.124              |    | .238   |    | -.361** |
|                   |                         | Sig. (2-tailed)         | .008            | 64 | .011             | 64            | .099          | 64                  | .330               | 64 | .059   | 64 | .003    |
| Family cohesion   | Correlation coefficient |                         | -.144           |    | -.154            |               | .120          |                     | -.149              |    | .398** |    | -.155   |
|                   |                         | Sig. (2-tailed)         | .256            | 64 | .224             | 64            | .347          | 64                  | .239               | 64 | .001   | 64 | .222    |
| N                 | Correlation coefficient |                         | .256            |    | .223             |               | -.014         |                     | -.068              |    | -.263* |    | -.218   |
|                   |                         | Sig. (2-tailed)         | .106            | 64 | .076             | 64            | .914          | 64                  | .594               | 64 | .036   | 64 | .083    |
| N                 | Correlation coefficient |                         | .106            |    | .076             |               | .914          |                     | .594               |    | .036   |    | .083    |
|                   |                         | Sig. (2-tailed)         | .64             | 64 | .64              | 64            | .64           | 64                  | .64                | 64 | .64    | 64 | .64     |

Table 7. Correlation Matrix for the READ and SDQ Subscales

### ***Gender Analysis***

Further analysis was conducted to determine if the overall results were significant for both males and females. There was little difference in gender from baseline to post-intervention in either the Connect-3 or Linked-Up group. The only significant difference was found for the Connect-3 group on the subscale of Personal Competency. Males significantly ( $p=.01$ ) increased their scores from pre-intervention ( $M=19.54$ ) to post-intervention ( $M=23.02$ ).

### ***Resilience and Adversities***

As hypothesised, most subscales of READ were negatively correlated with subscales of the SDQ, with the exception of the Prosocial scale, which was significantly positive (See Table 7). Specifically, the Prosocial scale was positively correlated with the subscale of Personal Competency (.31,  $p=.01$ ); Social Competency (.39,  $p<.01$ ); Social Resources (.40,  $p<.01$ ); Family Cohesion (.26,  $p=.04$ ) and was approaching significance for Structured Style (.24,  $p=.06$ ). Social Competency was positively correlated with Hyperactivity (.30,  $p=.02$ ).

### ***Attrition Rates***

For the 70 participants for whom pre-intervention data from the SDQ and READ measures were available; 29 (41%) of participants had post-intervention data available. There are also two participants in the Connect-3 group where post-intervention SDQ and READ data was available, but not their pre-intervention data. Given this low retention rate, independent-sample t-tests were conducted on each of the subscales and available demographics for the READ and SDQ to compare the baseline scores of the students for whom no post-intervention measures were available. The two groups were similar in all respects except for the Family Cohesion ( $p=.04$ ) subscale within the READ and the Peer Problems ( $p=.01$ ) and Total Difficulties ( $p=.02$ ) within the SDQ (see Table 8 overleaf).

## **Discussion**

The aim of the current study was to build on Worsley's (2014) research of the Resilience Doughnut model. Specifically, to assess the effectiveness of two programs based on the Resilience Doughnut model. The Connect-3 and Linked-Up programs are group-interventions that aim to help young people find their strengths, improve their social interactions and develop resilient thinking skills. The effectiveness of these programs was assessed by examin-

|                     | Post data not available | Post data available |              |
|---------------------|-------------------------|---------------------|--------------|
|                     | n=41                    | n=29                | Significance |
| Age                 | 11.14                   | 10.5                | .33          |
| Gender (males)      | 26 (61%)                | 16 (55%)            | .66          |
| Personal competency | 18.70                   | 19.55               | .54          |
| Social competency   | 13.62                   | 13.90               | .77          |
| Structured style    | 9.38                    | 10.59               | .10          |
| Social resources    | 15.27                   | 16.69               | .08          |
| Family cohesion     | 17.35                   | 19.45               | .04*         |
| Emotional problems  | 4.88                    | 5.54                | .26          |
| Conduct problems    | 3.24                    | 3.50                | .54          |
| Hyperactivity       | 5.40                    | 6.07                | .16          |
| Peer problems       | 3.31                    | 4.57                | .01*         |
| Prosocial behaviour | 7.50                    | 7.71                | .62          |
| Total difficulties  | 16.83                   | 19.68               | .02*         |

Table 8. Baseline measures for n=41 students whose time 2 data was not available compared to the n=29 students who completed both time 1 and time 2 measures.

ing pre-intervention and post-intervention measures of resilience, using the READ (Hjemdal et al., 2006) and adversities, using the SDQ (Goodman, 1997). The study also examined age and gender difference from pre- to post-intervention.

### ***Effectiveness of Resilience Doughnut Programs***

Results from the Connect-3 group show that there were significant changes in their scores from pre-intervention to post-intervention. Specifically, participants in the Connect-3 group significantly reduced their total difficulties score at post-intervention. They also had a significant increase in their scores for the Personal Competency subscale within the READ measure of resilience. Further, there was an apparent decrease in the subscales of Emotional Problems and Hyperactivity that were trending toward significance. Whilst these results provide some good evidence for Connect-3 program in reducing adversities, it is important to consider the clinical relevance of the scores. In all of the SDQ subscales, the mean participant scores fell within the 'average' to 'slightly raised' descriptive categories, suggesting that the participants did

not have a clinically high rate of difficulties even before treatment. This is not surprising, given that the study was completed with a non-clinical population.

Unlike the Connect-3 group (primary school aged students), the Linked-Up group (high school aged students), showed no significant change in scores from baseline to post-intervention. These results support the Lock and Barrett (2003) and Barrett et al. (2006) findings, which suggest that implementing programs with primary school-aged children appears to be more effective at reducing adversities than compared to high-school aged youth. Small participant numbers in the Linked-Up group may have impacted on these findings, given that there were only 22 participants at pre-intervention and seven at post-intervention. There was a non-significant increase in the Total Difficulties scores for the Linked-Up group, which appears more likely due to random variation rather than a type II error. Although these scores are based on only seven available participants, there appears to be no downward trend of the estimated marginal means from pre to post, which was apparent in the Connect-3 group.

However, in contrast to Barrett et al. (2006) findings, the results of this study found no significant difference in the changes from baseline to post-intervention for most subscales for males and females. The only exception was in the Connect-3 group, where male scores significantly increased on the subscale of Personal Competency from baseline to post-intervention. This unremarkable finding suggests that males and females generally do not respond differently to the Resilience Doughnut programs.

### ***Relationship Between READ and SDQ Scores***

As hypothesised, there was a significant increase in the resilience measure scores (READ) and decrease in difficulties scores (SDQ) at post-intervention, as seen in the correlation matrix of the two measures (Table 7), which is consistent with Worsley (2014) findings. However, unlike Worsley's (2014) study, a small number of the SDQ subscales did not have significant correlations against the READ subscales, such as the Hyperactivity scale. This is likely due to the type of participants within the group, who were more commonly referred for anxiety difficulties than problems with hyperactivity behaviour. In contrast to Worsley (2014) study (particularly the third case study), this research contained participants from socio-economically advantaged backgrounds.

Unexpectedly, Social Competency was positively correlated with Hyperactivity. This is again likely the result of the shy and anxious population. The Hyperactivity scale may be indicative of participants who were more extro-



verted and not hyperactive, as evidenced by the Hyperactivity scores being within the clinically normal range.

### ***Strengths***

The current study is the first to examine the effectiveness of the Connect-3 and Linked-Up group programs based on the Resilience Doughnut model. The data collected from this study provides further insight into the factors that build resilience in young people for a well-resourced population. These findings provide the platform to conduct further study of these programs within more diverse, and less affluent populations.

Another strength of this study is that the Connect-3 and Linked-Up programs are innovative, strengths-based programs, which aim to build resilience in a variety of domains, such as community and peer factors. Unlike other programs that may solely focus on developing an individual's characteristics (e.g., coping skills), the Resilience Doughnut programs are designed to engage young people in connecting with their family, community and other external resources around them. The READ subscales provide some measure of these resources, however future research could focus more specifically on how this broader view of resilience impacts on the effectiveness of the programs.

Finally, the difficulty in obtaining post-intervention scores for the READ and SDQ measures highlights the importance of having good quality assurance within the private clinic. This study has been the catalysis for improving the data collection system, including identifying technical issues with the computer-based program. Stricter procedures for the collection and recording of data will assist the clinic to conduct further rigorous research on the programs run at the centre. It will also allow the clinic to continue to contribute to the growing field of resilience-based research.

### ***Limitations***

There were a number of limitations to this research. Firstly, there were only a small number of participants within the Linked-Up group. These smaller numbers may have impacted on the ability to find significant change in scores on the READ and SDQ over time. Further research within the adolescent population is needed to assess this more thoroughly.

Another limitation of the program was the small amount of post-intervention data available. There were only 29 data points available for post-intervention analysis; however, this is not a direct indication of dropout rates,

as most participants completed the program in full. Rather, this low number could be due to technical issues, with the failure of the computer system to save the data properly. It could also have been due to some participants not attending the follow-up session, which is where most of the post-intervention data was collected. Attempts were made to get participants to complete the post-intervention questionnaires at a later date, however this was not always possible. The results from the independent-sample t-tests showed that only Family Cohesion, Peer Problems and Total Difficulties subscales were significant for participants who did not have data for post-intervention. It is unclear what may have contributed to this; however, it could be that participants who had more limited familial support were unable to attend the follow-up session for post-intervention data collection, as they had significantly lower Family Cohesion baseline scores. Alternatively, it could be that these participants did not attend the follow-up session because they did not need the intervention, as they had significantly lower scores for Peer Problems and Total Difficulties.

Another limitation was the small amount of demographic and descriptive data available to analyse the participant population. Specifically, no data was available to examine how many participants had completed previous interventions, or how many participants were getting other psychological intervention in conjunction with participating in the programs, particularly given that many referrals to the program came from psychologists. Similarly, there is a limitation for participants who self-referred to the program, as often self-referrals only capture a population that is likely to be interested and more engaged in the program and therefore may bias the results toward a positive response to the program.

Finally, the design of the current research presents a significant limitation. The current design was a pre-post test, with no control group. This limits the conclusions that can be drawn from the findings for the general effectiveness of the program.

### ***Recommendations for Future Research***

The current study examined the effect of the Connect-3 and Linked-Up programs on improving resilience scores with a small, homogenous population that is socio-economically advantaged, and therefore well resourced enough to already be resilient, as suggested by Ungar (2008). Future research may be interested in examining the effectiveness of Connect-3 and Linked-Up groups within a population that has increased adversity, as it may yield more clinically significant results. It could also be interesting to examine how these programs compare with other international resilience programs, such as the

Penn Resiliency Program (Gillham, et al., 2007).

Another area for future research could be to examine how these programs help to engage young people with the resources around them, such as their family and community, and how in turn, these resources build a young person's resilience. For example, the programs were designed to engage the young person's family through providing parent information sessions. The family and community were also involved in homework tasks, such as the kindness project, where participants had to develop a project that connected themselves with their available social resources (e.g., school, sporting club, family, faith-based community). Future research could aim to examine the impact of these connections on building resilience. This is particularly important as increasingly resilience is being defined as a process of overcoming adversity through using both individual and environmental resources (Ungar et al., 2008; Windle et al., 2011).

Finally, future studies should consider changing the design of the study. Rather than using pre-post test design, future research could consider using randomised assignment training and control groups. This would ensure more statistically robust results, which may provide wider scope for the clinical implications of the programs.

## Conclusion

The current research offers a perspective on building resilience in non-clinical child and adolescent populations through the Connect-3 and Linked-Up programs. These two 6-week programs, which are based on the Resilience Doughnut model, have demonstrated the ability to build personal competency and reduce total difficulties within a for young people aged between 8-12 years-old. However, more research is required to examine the impact of the programs within non-clinical and clinical population samples.

## References

- Australian Bureau of Statistics (ABS). (2013). *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA)*, (cat. no. 2033.0.55.001). Canberra: ABS.
- Barrett, P. M. (2012). *FUN FRIENDS: A facilitator's guide to building resilience in 4 to 7 year old children through play (3rd ed.)*. Brisbane, Australia: Pathways Health and Research Centre.
- Barrett, P. M., Cooper, M., & Guajardo, J. G. (2014). Using the FRIENDS programs to promote resilience in cross-cultural populations. In S. Prince-Embury, & D. H.

- Saklofske (Eds.), *Resilience interventions for youth in diverse populations* (pp. 85-108). New York: Springer. doi:10.1007/978-1-14939-0542-3-5.
- Barrett, P. M., Farrell, L. J., Ollendick, T. H., & Dadds, M. (2006). Long-term outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: an evaluation of the friends program. *Journal of Clinical Child and Adolescent Psychology*, 35(3), 403-411. doi:10.1207/s15374424jccp3503\_5
- Barrett, P., Lock, S., & Farrell, L. J. (2005). Developmental differences in universal preventive intervention for child anxiety. *Clinical Child Psychology and Psychiatry*, 10, 539-555. doi:10.1177/1359104505056317
- Benard, B. (2004). *Resiliency: What have we learned?* San Francisco: WestEd.
- Brown, H., & Prescott, R. (2006). Normal mixed models. In *Applied mixed models in medicine, Second Edition*, (33-105). New York: Wiley. doi:10.1002/0470023589.ch2
- Dunst, C. J., & Hamby, D. W. (2012). Guide for calculating and interpreting effect sizes and confidence intervals in intellectual and developmental disability research studies. *Journal of Intellectual and Developmental Disability*, 37(2), 89-99.
- Friborg, O., Hjemedal, O., Rosenvinge, J. H., & Martinussen, M. (2003). A new rating scale for adult resilience: what are the central protective resources behind healthy adjustment? *International Journal of Methods in Psychiatric Research*, 12(2), 65-76. doi:10.1002/mp.143.
- Fuller, A. (1998). *From surviving to thriving: Promoting mental health in young people*. Melbourne: Australian Council for Educational Research.
- Fuller, A., McGraw, K., & Goodyear, M. (1998). *The mind of youth—Initial findings from the Resiliency Project*. Unpublished report for the Department of Education, Victoria. Melbourne: Department of Education.
- Fuller, A., McGraw, K., & Goodyear, M. (2002). Bungy jumping through life: A developmental framework for the promotion of resilience. In T. Griffiths & S. Cooper (2005). *Social and Emotional Wellbeing in Schools: A review of systems' policies*. *Education Connect, Issue One*, 5-11.
- Gillham, J. E., Reivich, K. J., Freres, D. R., Chaplin, T. M., Shatté, A. J., Samuels, B., ... & Seligman, M. E. (2007). School-based prevention of depressive symptoms: A randomized controlled study of the effectiveness and specificity of the Penn Resiliency Program. *Journal of Consulting and Clinical Psychology*, 75(1), 9-19. doi:10.1037/0022-006X.75.1.9
- Gillham, J. E., Reivich, K., & Shatté, A. (2002). Positive youth development, prevention, and positive psychology: Commentary on "Positive Youth Development in the United States." *Prevention & Treatment*, 5(1), 18. doi:10.1037/1522-3736.5.1.518c
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38, 581-586. doi:10.1111/j.1469-7610.1997.tb01545.

- Goodman, R., Ford, T., Simmons, H., Gatward, R., & Meltzer, H. (2000). Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *The British Journal of Psychiatry*, 177(6), 534-539. doi:10.1192/bjp.177.6.534.
- Grotberg, E. H. (1995). The International Resilience Project: Research and application.
- Hjemdal, O., Aune, T., Reinfjell, T., Stiles, T. C., & Friborg, O. (2007). Resilience as a predictor of depressive symptoms: A correlational study with young adolescents. *Clinical Child Psychology and Psychiatry*, 12(1), 91-104. doi:10.1177/1359104507071062
- Hjemdal, O., Friborg, O., Stiles, T. C., Martinussen, M., & Rosenvinge, J. H. (2006). A new scale for adolescent resilience: Grasping the central protective resources behind healthy development. *Measurement and Evaluation in Counseling and Development*, 39(4), 84.
- Kohlberg, L. (1984). *The psychology of moral development: The nature and validity of moral stages (Vol. 2)*. San Francisco: Harper.
- Kovacs, M. (2003). *Children's depression inventory*. North Tonawanda, NY: Multi-Health Systems.
- Lock, S., & Barrett, P. M. (2003). A longitudinal study of developmental differences in universal preventive intervention for child anxiety. *Behaviour Change*, 20(4), 183-199. doi: 10.1375/bech.20.4.183.29383
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71(3), 543-562.
- March, J. (1997). *Multidimensional anxiety scale for children*. Toronto, Canada: Multi-Health Systems.
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227. doi: 10.1037/0003-066X.56.3.227
- Prince-Embury, S. (2014). Review of resilience conceptual and assessment issues. In *Resilience interventions for youth in diverse populations* (pp. 13-23). New York: Springer. doi: 10.1007/978-1-4939-0542-3\_2
- Seligman, M. E. (2002). Positive psychology, positive prevention, and positive therapy. *Handbook of Positive Psychology*, 2, 3-12.
- Ungar, M. (2015). Practitioner review: diagnosing childhood resilience — A systemic approach to the diagnosis of adaptation in adverse social and physical ecologies. *Journal of Child Psychology and Psychiatry*, 56(1), 4-17. doi: 10.1111/jcpp.12306.
- Ungar, M. (2008a). Resilience across cultures. *British Journal of Social Work*, 38(2), 218-235. doi:10.1093/bjsw/bcl343
- Ungar, M. (2008b) *The Child and Youth Resilience Measure, International Resilience Project*. Halifax, Nova Scotia: Dalhousie University.
- Ungar, M., Liebenberg, L., Boothroyd, R., Kwong, W. M., Lee, T. Y., Leblanc, J., ... & Makhnach, A. (2008). The study of youth resilience across cultures: Lessons

from a pilot study of measurement development. *Research in Human Development*, 5(3), 166–180. doi:10.1080/15427600802274019.

- Ungar, M., Theron, L., Liebenberg, L., Restrepo, A., Tian, G., Sanders, J., Munford, R., and Russell, S. (2015). Patterns of individual coping, engagement with social supports, and use of formal services among a five-country sample of resilient youth. *Global Mental Health*, 2, 1–10. doi: 10.1017/gmh.2015.19.
- von Soest, T., Mossige, S., Stefansen, K., & Hjemdal, O. (2010). A validation study of the Resilience Scale for Adolescents (READ). *Journal of Psychopathology and Behavioral Assessment*, 32(2), 215–225. doi:10.1007/s10862-009-9149-x.
- Werner, E. E., & Smith, R. S. (2001). *Journeys from childhood to midlife: Risk, resilience, and recovery*. New York: Cornell University Press.
- Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. New York: Cornell University Press.
- Windle, G., Bennett, K. M., & Noyes, J. (2011). A methodological review of resilience measurement scales. *Health and quality of life outcomes*, 9(1), 1. doi: 10.1186/1477-7525-9-8
- Worsley, L. (2014). Building resilience in three Australian high schools, using the resilience doughnut framework. In S. Prince-Embury, & D. H. Saklofske (Eds.), *Resilience interventions for youth in diverse populations* (pp. 217–257). New York: Springer. doi: 10.1007/978-1-4939-0542-3\_11
- Worsley, L. (2012a). *Connect-3 teaching materials*. Epping, NSW: The Resilience Centre.
- Worsley, L. (2012b). *Linked-Up teaching materials*. Epping, NSW: The Resilience Centre.
- Worsley, L. (2008). *The Resilience Doughnut: Accredited training manual*. Epping, NSW: The Resilience Centre.
- Worsley, L. (2006). *The Resilience Doughnut: The secret of strong kids*. Eastwood, NSW: Alpha Counselling Services.

---

### About the authors:

Kaitlyn Miller is a clinical psychologist registrar in the Child and Adolescent Mental Health Service, John Hunter Children’s Hospital in Newcastle, Australia and is an associate member of the Australian Psychological Society. Kaitlyn is also completing further study in applied policy and social research with an interest in developing policy using resilience frameworks.

Email: Kaitlyn.Miller@hnehealth.nsw.gov.au

Lyn Worsley is a Clinical Psychologist and Director of the Resilience Centre in Sydney, Australia. She is the author of *The Resilience Doughnut*, a pioneering model showing the strong contexts where resilience is enhanced, both during development and throughout adulthood.

Email: [lyn@theresiliencecentre.com.au](mailto:lyn@theresiliencecentre.com.au)

Tanya Hanstock is a Senior Lecturer and the Convenor of the Clinical Psychology Program at The University of Newcastle in Australia. She lectures in the area of child and family clinical psychology. Dr Hanstock has conducted a number of research projects in the area of child and adolescent mental health and has also supervised a number of students' research projects in this area. Dr Hanstock is also a Senior Clinical Psychologist who specialises in the assessment and treatment of children and adolescents. Dr Hanstock has a special interest in promoting resilience in young people.

Email: [Tanya.Hanstock@newcastle.edu.au](mailto:Tanya.Hanstock@newcastle.edu.au)

Megan Valentine is a research statistician with the Statistical Support Service at the University of Newcastle, and has assisted with study design and analysis across several disciplines, predominantly in Psychology and Special Education. Mrs Valentine is also a tutor in statistics for science students and public health for students studying medicine.

## **Solution-Focused work in the busy Emergency Department of a large city hospital. An interview with David Hains**

**Interviewed by Michael Durrant**

Brief Therapy Institute of Sydney

Solution-Focused Brief Therapy has experienced something of a resurgence in Adelaide, South Australia — largely due to the influence of David Hains. I invited David to reflect on his Solution-Focused journey.

**Can you tell me a bit about what got you into mental health nursing in the first place?**

Actually it was partly Professor Nicholas Procter (who is hosting our conference at the University of South Australia in a couple of months). In 1993, I was doing the first year of a nursing degree and Nicholas was one of my tutors. In July, we both ended up at a party where we didn't know anyone else so we sat together and chatted. Nicholas asked me if I had any thoughts about my future nursing career and what direction I might like to go in. Really, I had no idea. He then asked if I had thought about mental health and I replied "I have never thought about it, and I never will". At the end of 1996, I was finishing my graduate year and a 3 month contract became available to work in a mental health ward, There were 20 of us finishing at the same time and we all declined the offer. I then realised that I would be unemployed at the end of the year so I took the position, just so I could say that I had something to put on my resume. Three months turned into nine months, which turned into my career. Since then I have had several jobs where I was the only applicant, jobs that turned out to be absolutely perfect for me but in which no one else was interested. I don't know what that says about me!



**My guess is that Solution-Focused wasn't in your nursing training, so how did you come to embrace the Solution-Focused approach?**

It certainly wasn't in any of my training. I had been working for several years in emergency departments and I was thinking of doing a project of some sort but didn't know what. I decided that I would try to define the approach that we were using. We had a very small team that consisted of a psychiatrist, a psychiatry registrar, and a nurse. While it was medically led, we weren't really working under a traditional medical model. In fact, I remember one occasion when Prof Kalucy (our psychiatrist) was called into an urgent meeting with the head of surgery, the hospital risk manager and a couple of others to discuss an urgent surgical case with a patient who was also under the mental health act. Prof saw me walk past and called me into to room to ask my opinion. I made a couple of suggestions then left. Later, the head surgeon asked Prof why he had called me into the room and asked my opinion, and Prof replied, "that's just what we do". We had a team with a very flat hierarchy and, without knowing it, we were very "client centred" even though that term wasn't in common use.

**Brief Therapy approaches previously had some presence in mainstream mental health in South Australia, in contrast to the rest of Australia — I'm thinking of the Brief Therapy program within child & adolescent mental health in the 1990s and early 2000s (see references). What drew your attention to brief therapy?**

Working on this project, I was looking at brief therapy and how our approach might align with other brief therapies. That's when I stumbled upon SFBT — it was nothing like what we were actually doing but it instantly made sense to me. For years I had taken a not knowing stance, mostly because I just didn't know so I couldn't tell someone what to do anyway. Whenever anyone asked me, "What should I do?" I would be thinking, "Hell, I don't know what you should do" so I would just say, "That's tough, I don't know, but what do you think you could do?" SFBT then gave me some more reason and structure to the conversation. Why should I be telling someone what to do, when I can get them to tell me what they should do?

I later discovered that Tim Wand (mental health nurse practitioner, Royal Prince Alfred Hospital in Sydney) was also using SFBT in his ED and outpatient clinic. I had known Tim for several years and he is one of the most respected mental health nurses in the country. Tim put me onto you (Michael) and I later headed over to Sydney to attend a workshop at the Brief Therapy Institute of Sydney and also catch up with Tim in the ED. In the last few years

there has been an increasing number of nurses working in ED and psychiatry liaison positions using SFBT.

**Can you think of an example, early in your use of Solution-Focused, that really convinced you of its usefulness in the mental health context?**

Yes, absolutely. The very first patient I tried Solution-Focused with. He was a 50-something-year-old man who presented to the ED with shortness of breath. He was divorced and his two adolescent sons lived with their mother 2 hours drive away. He had been diagnosed with terminal lung cancer, was unable to drive any more and was connected to an oxygen bottle 24/7. The man was seen by the ED doctor and referred for a mental health assessment due to possible depression. That was the first “miracle” — that the man presented to the ED because of his trouble breathing, but the ED doctor actually picked up that he might be depressed and that mental health assistance might be helpful!

**What made you decide to try out your new Solution-Focused skills with this man?**

The reason I chose this man first was that I was looking for someone to experiment on, but I wanted someone that I didn't have to do my normal traditional assessment. I discovered that the man had had a full assessment at another hospital just a couple of weeks before, was diagnosed with dysthymia (I'm not sure why they would call it that but that's another story), and had the appointment to see the hospice psychiatrist already. That was enough reasons to give myself “permission” to experiment.

When I saw him, I simply tried to have a conversation using the little bit of Solution-Focused knowledge that I had. He initially presented as flat, low mood, low energy, low motivation. His self-care was a little poor and he couldn't see much hope for the future. The focus of my discussion was trying to establish both how he has coped so far, as well as his best hopes for the remainder of his life given his circumstances. During our discussion he told me that he was a car enthusiast and had a very nice old car sitting in the shed which he was unable to drive. Without me offering any suggestions, but using SFBT techniques, he was able to work out his desire and hopes. His one desire was to be able to teach his 16-year-old son to drive before he passed away. We explored what this might “look like” — he would contact his ex-wife, who would drop his children off on a Friday night, he would give his son driving lessons and do things like drive to Brighton and get ice cream, and

he would arrange for his wife to pick up the boys on Sunday afternoon. With almost no prompting, he was able to plan and describe this in a lot of detail.

### **So, what happened?**

I didn't see this man again, but always remembered his story. A couple of years later, I was talking about his story while I was running a SFBT workshop. One of the participants told me that she knew this man as she was working as a mental health nurse at the hospice at the time. She asked me, "do you want to know what happened?" and she told me, "He taught his son how to drive."

### **You currently work in the Emergency Department of a large city hospital. What does your work involve?**

My work in the ED now is more than just doing assessments although that is still a large part of what I must do. I often say that "people don't come to the ED because they are having a good day." While the traditional approach would be to find out all of the reasons why they are not having a good day, I know that doing an assessment will not actually make them feel better. My job is more about trying to turn people around. I might only have one chance or one interaction so I have to make it a good one. Some of the people I met in Canada such as Lance Taylor, as well as the team in Red Deer refer to this as a balanced assessment (Wright, Badescha and Schepp, 2014). This makes absolute sense to me in this environment.

### **How does using the Solution-Focused approach make a difference in this context?**

Incorporating Solution-Focused work into my day has made a huge difference both to the work I do and to my nursing career. I have been in this position for 10 years and it's rare for someone not to have been burnt out in that time. When you spend 12 hours a day listening to, and taking on, people's problems it can really wear you down. On top of that there are the political, environmental and time pressures in a department that sees about 80,000 patients a year, and in being attached to a hospital that is always at capacity. Then I come home to a busy house only to have my wife and kids wanting to tell me all about their problems! The time spent doing Solution-Focused work is more than just time spent not listening to problems. It is a chance for me to do something therapeutic, to help people, to remind me why I got into nursing in the first place. My patients usually walk away feeling good, and so do I!

**Tell me about the ED client who best illustrates how SF makes a difference in that context.**

Mary was a 50-something-year-old woman from the Adelaide Hills. She was previously a hard working woman in a traditional eastern European family. She was house proud, spent a lot of time cooking, keeping house, raising children, etc and helping her husband on their farm. Mary had an accident and badly broke her leg. She required surgery and internal fixation. Her leg got infected and she remained in hospital for six months on the strongest antibiotics we could serve up. On discharge, she continued on antibiotics and strong analgesia. Mary frequently represented to the ED saying the pain was uncontrollable and that she thought the infection had returned. She would be seen by the ED doctor who would not be able to do anything for her and they would spend the rest of the day trying to discharge her. She would usually refuse to go home as, far as she was concerned, nothing had been done and she was convinced that the infection had returned. The ED became increasingly frustrated with her reappearance. Over her subsequent presentations the “infection” and pain seemed to migrate up her legs, into her back, her abdomen, chest, neck, head ...

**How did you become involved?**

The mental health team was not involved until she said the magic word — suicide. “I might as well kill myself the pain is so bad”. To the ED staff, this was their chance to wash their hands of her as this was now a psychiatric problem. Mary was happy to talk to me but didn’t see that I had anything to offer as she believed she needed to be readmitted to the orthopaedic ward and needed stronger analgesia. At our first meeting, I must have spent the first hour listening to her problems and the second hour trying to extricate myself from the room, then referred her back to the ED saying there was nothing I could do. Mary must have had a copy of my roster since she only presented on the days that I was working, and I was usually the one that had to see her. Mary was hard work, and I later discovered that she had already burned through two different psychiatrists. I tried intervening a couple of times without any success. She was absolutely focused on the pain. I describe Mary as being like a black hole — when you were in her presence, all of your energy was sucked out of you and by the time you left the room you would feel completely drained but there was no change in Mary. I decided that I had nothing to lose so I would try to put into practice my new SFBT skills. I checked with her psychiatrist first, not wanting to step on any toes, but she said “PLEASE DO ANYTHING!”.

### **So, what “anything” did you do?**

At the time Mary next came to hospital, I was trying to get my head around exceptions and how to ask questions to find them. I knew that the problem couldn't be happening 100% of the time but it was hard because all I knew about Mary so far was that she was housebound (apart from coming to the ED), could not care for herself, could not cook, could not clean, could not keep house, etc. As far as I knew, the only thing she could do was to come to the ED. That is, until during my SFBT conversation, when Mary disclosed that she went to church EVERY DAY. Mary told me that she loves going to church, that she has many friends there, she has a strong faith, that they sometimes have lunch afterwards etc. We were able to identify that the pain was much less at church (or no pain at all) and she was able to cope with life and do activities. I also heard that, after church, many of the women would stay for lunch, and on the way home Mary might do something else such as go shopping. We were able to identify some strengths (e.g. that she could soldier on) and then identify other things that she could do. It was a very positive conversation.

Then the most amazing thing happened. Mary stood up, and for the first time initiated her own discharge. We walked out together, she shook my hand, and we said our goodbyes. Then the second most amazing thing happened: I returned to my office and realised that, for the first time, I had been able to talk to Mary and hadn't left feeling like all of the life had been sucked out of me. I actually felt good. Mary left with a feeling of hope for the future, and I left with a rejuvenation in my nursing career which has carried on and is strengthened every time that I do SFBT with a client.

### **Did you see Mary again?**

I have seen Mary a few times since then, but only bumping into her when she has presented for medical or physical issues. The frequency in her ED presentations decreased straight away. The ED doctors have not seen the need to refer her for a mental health assessment again. I note that a psychiatrist has readmitted her back to the inpatient unit once or twice, but I assume that was because their problem-based approach and focus on medication must have identified something that I didn't see the need for.

### **You won a South Australian Premier's award for your work as a mental health nurse. What was it that got you that award?**

Each year the SA Department of Health offers five scholarships for nurses to travel overseas to study something that might benefit nurses and the health

service in South Australia. I first started planning this in 2013, three years before actually arriving in Canada. My idea was to use Solution-Focused therapy to develop a model of care for nurses in the mental health setting. I can't actually claim this as my idea since I had read work from Margaret McAllister (2007) and Tim Wand (2010, 2013), but there was not much happening in South Australia. The application process involved researching what I wanted to do and where I wanted to go, then making contact with the relevant people around the world, planning the trip in detail and then submitting quite a detailed application, including demonstrating that it would benefit local health services.

### **So, where did you go?**

I was trying to find somewhere that was using SFBT in acute mental health services across various teams. After contacting various people in Europe and North America as well as the online SF List, I received an email from Phil Wright in Red Deer, Alberta saying, "I think we might have what you are looking for". My first thought was, "Great, but where the hell is Red Deer?". I went to Google and found the city homepage which told me that it was forecast to be -10°C on that day. I said to Phil that I wouldn't usually get out of bed if it wasn't going to be +10° at home, to which he replied, "If you come here you are going to spend a lot of time in bed". I held out for a while, waiting for contact from a service on a tropical island in the South Pacific but didn't happen. Phil put me in contact with Lance Taylor, Dene Shipowick, Darcy Jessen and others in Alberta, and I was eventually able to get a plan and an application worthy of a scholarship.

### **And you ended up in Nova Scotia? That's the other side of the country!**

I timed my trip so that it would coincide with the Solution Focused Brief Therapy Association conference in Halifax, Nova Scotia, then asked my boss if I could stay a little longer and attend the conference (conferences were not covered by the scholarship). My boss agreed to pay for part of the expenses, and SFBTA provided a free ticket to the conference. While I was there I was also able to attend a 2 day workshop with Lance Taylor and Heather Fiske, and got to meet some really interesting people like Elliott Connie & Adam Foerer, Frank Thomas, Jeff Chang, Joel Simon, and also Harvey Ratner from the UK and Ella de Jong from the Netherlands and so many others. I never would have imagined meeting so many passionate SF people in one place.

Given that my work in ED often involves working with suicidal people, it

was a privilege to meet Heather, who is probably **THE** international expert on using SFBT with acutely suicidal people (Fiske, 2008). When I was at Heather's house for the post-conference party, I got to tell Joel of my story with the terminally ill man (above). Part of the reason I was able to talk to this man was because the first SF book I had read (the only one at that time) was Joel's book on using SFBT in end of life and grief counselling (Simon, 2009). I think Joel was on the verge of crying when I told him the story. He said that he wrote the book because he thought it was a good idea and it worked, but it is only after hearing stories like mine that he knows it was all worthwhile.

### **What was a highlight from the trip?**

Amazingly I had been using SFBT for a few years but as I was on my own in Adelaide I had never seen anyone do a live session. In Canada I was able to sit in on many sessions and for me I was about as excited to do this as I was to read about the early days in Milwaukee where people could observe and discuss sessions and learn as they were happening. We just don't have that culture here.

I saw a lot of sessions over a few weeks and really enjoyed it. On my last day in the Red Deer Community Mental Health Clinic it was a Tuesday and they run a solution focused drop in clinic. There were about 15 staff who all met in a room and waited for clients to walk in. We then divided up where one would interview and several would observe. The first client arrived about an hour before the clinic opened — it was about -2° outside and I just could not believe it.

After observing all of these interviews, I was amazed at how all of these clinics seemed to attract all of the nice people. Why don't nice people ever come to my ED? I only ever get to see the ratbags, the PD's, the drunks and druggies, the malingerers, etc, but I never get to see the nice people. The last client in Red Deer was a young man who was brought in by his girlfriend. They were both drinking every day and there was a lot of conflict in their relationship. However doing the interview I heard that this man was training to be a chef, that he had just won a big competition and he as in training to go to Mauritius for a world cooking competition. I heard about his strengths, resources and ambitions, and the clinician was really skilled in getting his vision for his preferred future. I was feeling really positive about this young man's future, and again I was left to wonder why I never saw men like that in my ED.

Then I had a big revelation. The week before this interview the man had attended the Red Deer ED. He was drunk, he had had a big fight with his girl-

friend and in the process had smashed a beer bottle and had ripped open his hand. I imagine he would have been belligerent, perhaps aggressive. We would have identified his alcohol addiction, his impulsive behaviour, domestic violence, and perhaps even a personality disorder. We would have suggested he see the drug and alcohol service and anger management program, and would have been 100% certain that he would not have attended. I then realise that the outcome will be determined by the questions that we ask. If we look for problems, we will only find problems. If we look for solutions we will find solutions.

### **And what else?**

Another highlight was seeing Solution-Focused group work in both Red Deer and Ponoka. I had never been involved in group work, and I wasn't looking for it while I was away, but the things they were doing there were unbelievably simple and yet so very effective. I asked the participants why they would leave their home on a Monday night when it was -1° outside. They unanimously said that they got so much out of it that couldn't miss it. Likewise, in the inpatient rehab unit in Ponoka, I saw the patients turning up to the group 15 minutes early and they sat there with their workbooks on their lap all ready to go. I never would have imagined that patients in a rehab ward would be early for anything, but again they said they got so much out of the group that they wouldn't want to miss it. Since I've returned to Adelaide Solution-Focused groups have been implemented in Noarlunga Hospital with great success.

### **You are THE key person in organising the 2017 Australian Solution-Focused conference. What are your "best hopes" from the conference?**

Coming back to Adelaide and having an offer from you (Michael) to hold the Australasian SFBT conference was just a dream for me. After attending the 2nd AASFBT conference in Sydney I wondered if we would ever have enough interest in SFBT in Adelaide to host a conference, and a couple of years later here we are. By the time this is published the conference will probably be over, so one of my hopes is that we will still be able to talk about the conference in a positive light after July. There are a lot of things I am hoping for with the conference. Firstly, the growth of SF work in Adelaide has occurred mostly in acute mental health areas, so I would love for clinicians here to be able to show that off to the rest of the world, which will in turn inspire the people here to continue their work. Secondly, I would like to see the conference kick-start some growth in SF work outside of the mental health world — such as



schools — I know there is a bit happening with some school counsellors but I would love to see more. On a more personal note, I would like to learn about using Solution-Focused approaches within organisations, so I am really looking forward to hearing about the work of Sophie Giesler and others. Finally, I would like to understand just a little about the philosophical underpinnings of SFBT, that Dan Hutto writes about — his work looks impressive, but I just have absolutely no idea of what he is talking about!

### **And you've gone on to establish a South Australian SFBT interest group.**

A few years ago I was asked if I would run an occasional 1 day workshop on SFBT to staff in the public mental health service here in Adelaide. The workshops seemed to go well and, after a couple of years, I had a few people approach me asking how we could learn more and spread the word on how good this was in the mental health service. We decided to have a meeting and put together a few ideas. There were 5 of us at the first meeting, and we decided to set up a regular get-together for education, support, peer supervision, and promotion of SFBT. We decided to establish ourselves through the Mental Health Professionals Network for the simple reason that they provided money (for catering and expenses) as well as a little admin support (for advertising, attendance lists, and certificates of attendance). We ran our first meeting in April 2016 and have met every 3 months since then. We now have a membership of over 100 names, with people from both public and private health as well as school counsellors and NGO workers. A few months ago, the South Australian SF Community of Practice formally affiliated with AASFBT.

### **Finally, what's this "Left Turn"?**

With a growing interest in SFBT in Adelaide, I was getting enquiries from different organisations to run training. As some of these people could not access the normal training I was offering through the public mental health service I decided to set up a small business so I could provide this training in a private capacity. Hence Left Turn Solutions was born. ("When things aren't going right — turn left"). It's not enough work for me to be able to give up my day job, but the ability to do this has meant more people in Adelaide can access Solution-Focused training. I have run workshops for the Mental Illness Fellowship of South Australia (a non-government organisation) as well as the Southern Adelaide Complex Care Team (a non-mental health team who assist with complex multi-dimensional problems). I have future workshops planned with mental health and non-mental health teams.

## References

- Allison, S., Roeger, L., Dadds, V. & Martin, G. (2000). Brief therapy for children's mental health problems: Outcomes in a rural setting. *Australian Journal of Rural Health, 8*(3), 161-166
- Allison, S., Stacey, K., Dadds, V., Roeger, L., Wood, A. & Martin, G. (2003). What the family brings: gathering evidence for strengths-based work. *Journal of Family Therapy, 25*, 263-284.
- Dadds, V., Roeger, L., Stacey, K., Martin, G., Wood, A & Allison, S. (2001). Maintaining the gains: What worked in the year after brief family therapy, *Australian & New Zealand Journal of Family Therapy, 22*(4), 181-188.
- Fiske, H. (2008). *Hope in action: Solution-focused conversations about suicide*. New York: Routledge.
- Simon, J. (2009). *Solution Focused practice in end-of-life and grief counseling*. New York: Springer Publishing.
- McAllister, M. (Ed.) (2007) *Solution Focused nursing: Rethinking practice*. Palgrave MacMillan.
- Wand, T. (2010) Mental health nursing from a Solution Focused perspective. *International Journal of Mental Health Nursing, 19*, 210-219
- Wand, T. (2013) Positioning mental health nursing practice within a positive health paradigm. *International Journal of Mental Health Nursing, 22*, 116-124
- Wright, P., Badesha, J., & Schepp, G.K. (2014) Balancing a solution focused approach with traditional psychiatric assessment in a Canadian emergency room. *Journal of Systemic Therapies, 33*, 24-34

## About the authors

David Hains is a mental health nurse with 15 years' experience working in emergency departments in Adelaide, South Australia. He is coordinator of the Adelaide SFBT Community of Practice, a board member of the Australasian Association for Solution-Focused Brief Therapy and convenor of the 2017 Australian & New Zealand SF Conference. In 2016, he established Left Turn consultancy as a way of both expanding his SFBT teaching and consultancy and as an opportunity to move (slowly and tentatively) into private practice.

Email: david@leftturnsolutions.com.au

Michael Durrant is Director of the Brief Therapy Institute of Sydney, President of the Australasian Association for Solution-Focused Brief Therapy and Editor of this journal.

Email: michael@briefsolutions.com.au

## Words

**Evan George**

BRIEF, London

Originally published on the BRIEF Facebook page, November 2016

Words are weasely, they are like snakes. They slither about and we hardly notice them. They sneak around barely visible and yet as they go they can change everything in their wake. Let's take the little word 'get'. It's a small word, an everyday sort of word, not the sort of word to which we would pay much attention. It is a workaday word that pops out of our mouths, a word whose definition we would never look up, a taken-for-granted word, an unshowy sort of word that lives in the shadows doing its work quietly, never attracting attention to itself. It is, to all intents and purposes, a modest word.

But the word 'get' is also a trouble-maker, a stirrer, a rapsallion, a veritable rascal of a word. It is a Trojan Horse carrying within those three letters a much larger set of assumptions, assumptions which can derail our attempts to work in a Solution-Focused way with our clients. Let's consider the following apparently entirely inoffensive statements "I was trying to get him to describe his preferred future" or "I wanted to get her to be aware of her strengths". So what's the problem with these statements? Both seem like good ideas. Describing preferred futures and 'noticing and naming' strengths are both processes that lie at the heart of the Solution-Focused approach — aren't they? Shouldn't we try to get people to do these things? And the answer of course is no we should not. We should never try to get people to do things. As soon as we are in the getting business we are using force. And as soon as we use force then we create the likelihood that the client will respond with what we could describe as 'counter-force' or, more commonly 'resistance'.

But what alternative words do we have? It is not easy. The language becomes clunky and awkward. It is less than perfect. However, I would choose to say that we 'invite' people. Every question is an 'invitation'. We are asking questions that 'invite' people to describe things. When we use force and the force is resisted the logic of the language suggests to us that we should use

more force. That's how force operates. I do it to you. However if an invitation is turned down the word suggests that I may need to have another look at the invitation. Is the invitation attractive enough, is it timely, is it interesting to the recipient? How could I change the invitation such that the chances of acceptance are increased? After all I cannot make anyone accept an invitation. That is not what the word means.

Many thanks to the participants on this week's Solution Focused Supervision and Consultation programme at BRIEF in London for triggering this reflection.

### **Comment from Don Coles**

Thank you, Evan, for these helpful reflections on our use of language, and implications in therapy of the difference between 'getting' and 'inviting' something from someone. I agree an approach of invitation is clearly more consistent with the collaborative, meaning emergent, process of Solution-Focused practice.

Your comments got me wondering about the possible effects of power differentials as these words are used. I'm picturing an employee who has been 'invited' by a manager to consider a particular course of action — it may be couched in collaborative terms, but it could be a direction in disguise. It may not be helpful for the employee to 'decline' the invitation and it would at least be reasonable to have a clarifying discussion about what the invitation means, if there is some ambiguity. At its worst, an invitation can be a threat. Parents become masters of framing directions in the form of invitations. In therapy, there is a different sort of power differential, but how do we take care that our 'invitations' are not read or received in way that is not too far from 'getting'? We could have the same discussion about the use of the terms 'request' or 'ask' — close relatives of 'invite'.

This discussion does help us to reflect on influence. Say a client does something that I ask them — for example I might invite (ask? request?) them to think about what resource or ability they utilised to manage a problem and they come back to the next session having done that. What's the connection between me having asked them that, and them having taken it up? Whether I think I 'invited' them to consider this, or I 'got' them to consider it, what actually was or is the mechanism? Perhaps more importantly, did their consideration of that question actually assist them in the work towards the goals they are expressing in the therapy? We may be able to come to some sense of how the invitation process (or the getting process) actually works, but did it lead to something useful for the client?

Anyway, I hope I have been able to get ... oops, invite ... people to think about this issue a bit more!

*Don is a social worker and counsellor, with experience in working with children, teenagers, adult, couples and families, together with training and supervision, in a variety of settings. He is currently with the counselling team at the (Australian) Royal Commission into Institutional Responses to Child Sexual Abuse. doncoles@tpg.com.au*

### **Comment from Thorana Nelson**

I so totally agree with Evan's ideas here that it's like trying to describe air. Of course! Of course not! Why would one? Why not? On and on. The notion of 'inviting' has so totally taken over my way of thinking that I surprise myself when I must step outside of my cozy world and look at it from a different angle, or catch myself by thinking I know what the client's air is like.

A client once said to me, "he was in the living room" with great emotion. "He was in the living room!!!" What does that mean? — That one is easy. However, another client once said to me, "I had to take out the garbage" and I didn't even blink. A student challenged me on this: What was my assumption? The garbage needed to go out? Someone else should take out the garbage? Oh!

Back to inviting. When I remember that clients invite me to cooperate in different ways (de Shazer, 1984), and I don't take offense or assume I know what they mean, it's easier for me to invite them to ... describe further, explain meaning, scale their position, ask about exceptions, ask relationship questions, etc. The context, including the client's words, helps me decide which questions to ask, but I don't pretend to know the answers until I hear the client's reply. I don't even know for certain what question the client heard! However, if I take offense at the invitation, or allow my assumptions to kick me in the a\$\$, I'm more likely to attempt to 'get' something. As if I have more than the barest (and perhaps mistaken) clue what's going on in the client's world.

So, here's to invitations — the ones we get from clients and the ones we give them.

de Shazer, S. (1984). The death of resistance. *Family Process*, 23, 79-93.

*Thorana is professor emerita of family therapy in the Department of Family, Consumer, and Human Development at Utah State University. She is a founding*

*member and recently-retired secretary/treasurer of the Solution-Focused Brief Therapy Association, and is a trainer and supervisor of Solution-Focused Brief Therapy.*

*thorana.nelson@emeriti.usu.edu*

### **Comment from Ian Johnsen**

Evan's blog post reminds me of the discussions my colleagues and I have had over many years — conversations about the difference between manipulation and influence, understanding how expert versus local knowledge is important, thinking about unilateral versus mutual processes and how we, as human beings, think, feel, act, (respond) to these things (manipulation, expert knowledge, unilateral power).

Evan invites us to look at what we as solution-focused actors actually do in counselling or therapy conversations — including what words we use. “Modest” words are often the most powerful because they work in the “shadows”, unseen. Do we “get” or “invite” clients to talk about their hopes? Do we work “with” or “for” clients?

I'm reminded of a quote from Steve de Shazer, now dimly remembered, something about how each word is like a locomotive engine, pulling along freight loads of meaning. We might talk about what a particular word means and try to fix it in place for a moment, for the duration of our conversation, but it is difficult to “fix” and “foreclose” meaning in a “once and for all” kind of way. It is not only everyday words like ‘get’ that work like Trojan Horses, indeed professional discourse maintains a mask of authority and a claim to legitimacy by ‘fixing’ what words can be said to represent or mean. For some of the implications of this see for example, Coates and Wade (2007). Wittgenstein, who Steve talked about often, used to say that the meaning of a word is in how it is used.

This fixing of meaning is problematic even in some of the discourses we identify as ‘progressive’. For example in the ‘strengths based movement’ and in the various discourses about resiliency, professional discourse works to reify and nominalise what is fluid and active. So, we come to talk of people as ‘being resilient’ rather than understanding that resilience is something people do, a social fact, not an individual trait but a community achievement. And we come to measure strengths as if people have them or not, as if they exist as an entity, in themselves, something to be normatively quantified.

The word “get” can reveal a kind of posture that amounts to using “force”, as Evan points out. But with the word “invite”, we can also conceal that we do

indeed use influence and “power”. The therapist, like the doctor or teacher or lawyer, is usually the person who assumes the right — or position — to ask most of the questions. This in itself means that we do more than “invite”.

Every question works like a flashlight in a dark room, no matter how collaborative it seems to be. It “asks” a person to look here, not so much there, and talk in this way, not so much that way. Conversation analysts talk about “sequential constraints”. A question imposes “constraints”, useful and socially just constrains ideally, but constraints nonetheless. If I ask, “What is your name?”, and you reply, “Manchester United”, we have a small social problem. The asking of a question “constrains” a person to provide a “relevant” response — that is, a response that is relevant to the content of the question. To use Steve’s analogy, questions are the locomotives that pull the freight.

It is precisely because conversation works in this way that Evan’s caution about the word “get”, and by extension other similar terms, is so important. Because as therapists we do exercise influence and power, it is up us to be vigilant about our intentions and how we represent our actions.

As Evan suggests, in Solution-Focused work we are always guided by our client’s hopes. In dialogue with our clients we seek to build as detailed a description as possible of these hopes. A description of all the things, past, present and future that have been, are, or could be in the clients life that are signs that what the client hopes for is, either to some extent already happening, or possible. As this therapy is not about our expert understanding of the individual mind, or our clever interventions or other special knowledge we can impart, in Solution-Focused work we hope our conversations will “leave no footprints”. We trust in the process and we trust in the pre-existing competence of our clients.

A quick story — I attended the BRIEF summer school some years back with Evan, Harvey and Chris and I was particularly struck by the ‘rotating interviewer’ exercise. This was a group exercise with pairs of role-playing ‘interviewers and interviewee’s — an exercise based on an original exercise from Peter Szabo. I think that understanding how this exercise works is a big part of understanding how Solution-Focused therapy works. The exercise involves asking a few key questions about 1. Hopes (or miracles), 2. What’s working already? 3. The sense of how far toward realising hopes a person is (scaling), and 4. What the next small signs of realising hopes will be? Okay, pretty standard stuff in the Solution-Focused canon; however, in this exercise at every new question the interviewer changes and the interviewee is asked the next question by a new interviewer. What is important here is that the ‘client’/interviewee is able to continue to build detailed description around their hopes and of course any ‘agenda’, ‘footprint’, ‘force’ or ‘expert knowledge’ of

the interviewer is shown to be, at the very least, unnecessary.

This exercise highlights that counselling requires expertise but only a particular type of expertise, that of understanding the process that brings description alive for the interviewee. Thus, of course, any other interviewer with the same expertise of this conversational process will be, for the purposes of detailed description around client's best hopes, equally useful.

Of course, this is an exercise tailored to just some elements of what happens in a Solution-Focused counselling conversation. One key element that we are missing in this exercise is that of 'Solution-Focused listening'. It is after all the listening for specific words and turns of phrase used by the interviewee that must determine what is reiterated and woven into the conversational process.

Finally, after reading Evan's post, I was prompted to reflect on the difficulties I sometimes face when in family work and I am required to respond to the competing agendas of multiple people in the one room. Sometimes I feel less like a partner in constructing a useful dialogue and more like a police officer directing traffic. I like to think that I only invite description but what about when others in the conversation really do want a son or daughter or partner to 'get' something or when there are multiple descriptions to be teased out. At those times I'm aware, usually post session of having shared one story too many, pushed one barrow too many, or aligned myself with one person's hope more than another's. Well that's a theme to keep returning to in supervision!

Coates, L. & Wade, A. (2007). Language and violence: Analysis of four discursive operations. *Journal of Family Violence*, 22, 511–522.

*Ian Johnsen is a family therapist, psychologist and human resources/family and child protection consultant in private practice in Wollongong, south of Sydney, Australia. He wishes to acknowledge that Allan Wade, from the Center for Response-Based Practice in British Columbia, Canada, contributed to these comments.*

*consult.ianj@gmail.com*



## **Preventing suicide: The Solution-Focused approach (2nd edition).**

John Henden

2017. Chichester, West Sussex: Wiley Blackwell.

Paperback, 336 pages. \$AU78.95/€42.00 (Also eBook — various formats)

### **Review by David Hains**

Director, Left Turn and Clinical Practice Consultant, Emergency Department, Flinders Medical Centre, Adelaide, South Australia.

The first edition of Henden's book was the second Solution-Focused book that I read, perhaps seven years ago. As a front-line clinician with a newly developed passion for SFBT, the book seemed like the natural choice. If I was going to make SFBT work for me in the hospital Emergency Department (ED), and for it to be accepted within my team, it had to work with clients who were complicated, high risk, anxiety provoking and "difficult". It had to work with common-type presentations. It had to do good, be easy to use and "add to the client journey" through the department. However, it could not (noticeably) add to the length of time the client had to spend in the department.

The suicidal patient is perhaps the person who is most at risk from the "medical model" as the clinician's natural reaction to control and contain the risk (i.e involuntary admission) can possibly be more detrimental in the long term. So, could a Solution-Focused approach be a valuable addition (or alternative) to dealing with a suicidal client?

The ED is rarely considered a place to do therapy. Like many parts of the world, Australia has imposed time restraints meaning there is only time to do a checklist-type assessment and then referral in the purest medical model style: symptom/problem identification, diagnosis, suggestion, referral. Certainly, there is little time for compassion, conversation, care or therapy. It's always been my goal to combine assessment with treatment. We know people don't come to the ED because they are having a good day. We know that an assessment on its own does not make people feel better (and possibly makes them feel worse) and we want people to feel better when they leave com-

pared to when they arrive. How can that happen in just a short time in the ED?

John Henden's book was the first to give me both permission to actually do something beneficial or therapeutic in the ED and a structure, through the use of SFBT. Now I was really in a bind: do I fulfil the organisational requirement of information gathering and risk assessment or do I try to do something useful? The age-old battle of good versus evil was now consuming my work.

Henden's original edition was well accepted by front line clinicians wanting to use SFBT with clients who are at their lowest point. The book contained a solid foundation with an introduction to suicidology, current service provision (including the pitfalls of the medical model, risk assessments, and many of the common practices) and an introduction to 6 commonly used therapies. However, it is in chapter 6, by far the longest chapter, that things start to get really interesting by turning our thoughts firmly towards SFBT. The chapter provides a good introduction to SFBT with the history of its development and a description of many of the techniques one might use in a traditional SF approach. That is, it steers away from some of the more contemporary SFBT thinking in favour of a more traditional approach, one that remains in common use by many Solution-Focused clinicians around the world. There is nothing new or cutting-edge here, just a good solid SF foundation to build the rest of the book on. The chapter includes several case examples, snippets of conversations and examples of questions to help the reader see how to actually use the approach.

Before moving on to The Solution-Focused approach in working with the suicidal (chapter 8), Henden slots in a short but vitally important chapter on relationships and the crucial first ten minutes. As an ED clinician, we tend to work in seconds and minutes (compared to elsewhere, such as an inpatient unit that works in days and weeks), so this chapter had great meaning for me. This also equally applies to all brief therapists; there is no time for slow or extended rapport building. As Henden says, get it right in the first few minutes and the whole course of the conversation/treatment changes and potentially a life is saved. Get it wrong and there is another potential statistic.

Chapter 8, the second longest chapter, is where SFBT and suicide prevention come together, building on a relationship established in the first few minutes. Again, there are a lot of questions and conversations used as examples that all front-line clinicians could use and relate to. Chapter 9 is a larger case study over 8 sessions, and chapter 10 a selection of case vignettes.

Skip forward 7 years. The opportunity to review the second edition of the book was for me an opportunity to consider if the book in retrospect was so good that I am still using the approach in my practice or have I moved on

to something else. It had been a while since I had read the book and there have been significant changes in my practice, in local service provision and in contemporary Solution-Focused thinking. However, in many ways, the approach outlined in Henden's book remains more relevant than ever. SFBT has remained my core approach, thanks at least in part to the foundation that the book provided.

So, as a devotee of SFBT, for a review of the second edition it seems only natural to ask, "What's better?" The second edition contains the obligatory minor updates in referencing and research for those first 10 chapters so essentially there are only slight changes. However, Henden has included 5 new chapters, enlarging the book by 30%, and has modified some of the concluding chapter and appendices.

The first new chapter, "Connecting with people", was written by Dr Alys Cole-King. The Connecting with People organisation (CwP) is a UK based not-for-profit organisation that focuses on suicide mitigation (rather than risk assessment) and seeks to translate research into practice ([www.connecting-withpeople.org](http://www.connecting-withpeople.org)). At first, it might seem somewhat unusual that SFBT is not mentioned in the whole chapter. Henden introduced CwP back in chapter 2 and at several other places in his book and makes it clear that he has a lot of respect for both their research and approach. Henden compares his concept of 'deep empathy' to the CwP focus on 'compassion' (personal communication). While CwP is not in itself Solution-Focused, certainly the two have potential to work well together. An interest for me is that colleagues at Noarlunga Hospital (southern Adelaide) in 2016 had already started to combine the two approaches by introducing SFBT and CwP into their inpatient unit. (Since then CwP has been rolled out across the whole of the South Australian mental health service in the first large whole-of-service roll out anywhere in the world, so I am personally interested to see how we can make SFBT and CwP work together). However, in the book's context, chapter 11 adds more to the previous information on suicidology and therapeutic relationships than it does to SFBT, but I say this in a positive light.

Other new chapters include: Working on the phone, Blaming those who took their lives, International Solution-Focused applications and Zero suicide. Of particular interest to me (and perhaps understated in the book) was a reference to the work done in Red Deer, Canada (Wright, Badesha & Schepp, 2014) where their approach to "balanced assessment" potentially meets the needs of both clients (therapeutically) and the organisation (information gathering and documentation) in a somewhat seamlessly blended emergency room assessment. The more balanced assessment allows a more accurate assessment of both the level of risk and also the client's level of resources.

Having seen this approach first hand, my suggestion to Henden is that this topic needs a chapter to itself.

The final chapter is a rewrite of “Where do we go from here”. Henden describes his work as “a how-to-do book” but to be used in conjunction with training workshops and supervised practice. However, his desire is to work towards a manual for using SFBT to help suicidal clients. For beginning clinicians (like I was when I read the 1st edition), this book has more than enough to get started on doing some good Solution-Focused work with suicidal clients and, while there are many practical suggestions and good case examples, it is, as Henden suggests, far from being a manual.

What’s still missing? — Since the first edition, there has been no new solid research on using the Solution-Focused approach with suicidal clients. More research with rigorous design is needed. Henden admits this, but hopes that with the wider uptake of SFBT within acute services there is at least more possibility to do this now.

Don't buy this book if you:

- are a beginning practitioner and want to know about SFBT.
- want the latest research on suicide prevention (the book does give a bit of this, and tells you where it comes from such as CwP).
- want the very latest news/practice/philosophy/techniques on SFBT
- don't work with suicidal clients.

Do buy this book if you:

- already know a bit about SFBT and want to use it in crisis intervention, suicide prevention, and front-line mental health services (or anywhere that deals with suicidal people).
- want to see case examples.
- want “permission” to use SFBT in the front line i.e. that you would prefer to do something therapeutic for your client, rather than conduct a traditional or risk assessment and then panic or react to that.

Both locally and around the world there appears to be a momentum building where front line clinicians are realising that we need to move away from the traditional assessment with focus on problems and risk, to a more therapeutic or balanced assessment. This book may be the starting point for many more clinicians to do this. The result can only be good. Hopefully by the third edition Henden can highlight more of the wonderful and innovative work of front line Solution-Focused clinicians and include an evidence base to support the topic that he is passionate about.

## References

Wright, P., Badesha, J., & Schepp, G.K. (2014). Balancing a Solution-Focused approach with traditional psychiatric assessment in a Canadian emergency room, *Journal of Systemic Therapies*, 33, 24–34

## The reviewer

David Hains is a mental health nurse with 15 years' experience working in emergency departments in Adelaide, South Australia. He is coordinator of the Adelaide SFBT Community of Practice, a board member of the Australasian Association for Solution-Focused Brief Therapy and convenor of the 2017 Australian & New Zealand SF Conference. In 2016, he established Left Turn consultancy as a way of both expanding his SFBT teaching and consultancy and as an opportunity to move (slowly and tentatively) into private practice.

Email: david@leftturnsolutions.com.au

---

## The power of the next small step: What's the best that could happen?

Rayya Ghul

2015. Dallas, TX: The Connie Institute

Paperback, 134 pages. £6.99 (Also eBook — various formats)

### Review by Frances Price

Canberra Grammar School

Having completed my psychology internship with a Solution-Focused psychologist, the question, "What is the best-case scenario?" is very familiar to me. It does, however, speak against most of what we see, hear, talk about and focus on in our daily lives. In her book, *The power of the next small step*, Rayya Ghul provides an easily accessible foray into Solution-Focused thinking and explains simple ways to take that "next small step."

This is fundamentally a book for clients — a Solution-Focused self-help book. However, unlike some other self-help books, it is not opaque about the specifics of the therapeutic approach. It openly explains the ideas behind Solu-

tion-Focused techniques to people who might want to make some changes in their life.

Writing in a conversational style, Rayya takes her readers through the Solution-Focused way of thinking and provides practical ways people can be agents of change in their own journey. The basic tenets of Solution Focus are explained step by step, allowing people to dip in and out of the material, revisiting as needed.

While reading this book I found myself thinking of several friends, family members and colleagues who may appreciate/benefit from/engage with this book. As Rayya describes in the introduction, this book was written to bridge the gap between the Solution-Focused practitioner and those who are interested in applying it in their own lives. With expert advice “only going so far,” Solution Focus provides a framework to help people be the experts in their own lives.

Beginning the book with a chapter on myth busting allows the reader to question their assumptions and ideals they may have been pushing themselves towards without necessarily being aware of this. Rayya provides practical examples that allow the reader to step back from a predetermined ideal and focus on ways of making a shift — right now. The ‘Miracle picture’ or ‘preferred future’ of Solution Focus is explained in a way that helps the reader see its practical benefit for the here-and-now. By stepping through the miracle activities, you give yourself permission to dream success rather than just survive. You can create a compass for what you’re aiming for rather than focussing on what you’re trying to avoid. Filling the picture of your preferred future with specific details allows you to ‘hook in’ to what is important and meaningful to you.

I also loved the terminology of making sure you remain Solution-Focused rather than “solution forced”, using it as, “a way of co-operating with life instead of grappling with it and trying to bend it to your will.” Rather than seeking out the perfect answer to a ‘problem’ we’re presented with, Solution Focus encourages you to treat small steps as experiments, “whatever happens is simply useful information.” Rayya’s practical activities and real life stories guide the reader through engaging with these ideas and reflecting on them in their own lives.

This book provides a straightforward introduction to the field of Solution Focus that is easy to engage with, a perfect starting point for those new to Solution Focused ideas. For those familiar with Solution Focus, this book could serve as a conversational reminder as well as being a resource you could recommend to clients or people in your life who express curiosity about all things Solution Focus.

## **The reviewer**

Frances Price is a psychologist who works in both the school and private practice settings. Having completed her registration training with Lyn Worsley at the Resilience Centre in Sydney, she has a passion for helping children and families identify their personal strengths and resources to navigate and negotiate successfully with their surroundings. She has been lucky enough to attend Solution-Focused conferences both in Australia and overseas and loves the professional collaboration involved in those events. She is Secretary of the Australasian Association for Solution-Focused Brief Therapy. Frances currently works in Canberra and, while she keeps in contact with Solution-Focused colleagues in Sydney, is open for new professional networks in the ACT.

Email: frances@theresiliencecentre.com.au

---

## **Focus on solutions: A health professional's guide (Revised second edition)**

Kidge Burns

2016. London: Solution Books.

Paperback, 192 pages. £12.99/\$AU11.99 (also Kindle)

### **Review by Jonas Wells**

National Network of Coordination Agencies, Sweden

This is a revised second edition of the 2005 book on Solutions Focus set in the world of health professionals. The author has long experience, more than 20 years, working with and training speech and language therapists, physiotherapists, occupational therapists, dietitians, nurses and social workers. This book very well reflects that breath of experience as there are countless examples from real practice, both longer case examples and transcripts of whole conversations, as well as many snippets of a wide range of different types of conversations with different adaptations of Solution Focused techniques with a wide range of clients. It has been a delight to read and delve into. Especially for me, it has been rewarding as I work with coordinating and training health professionals. I find it quite rare to come across a book I would so readily recommend and place in my colleagues and fellow professional's hands. It has been very refreshing to find all these recognizable situations and examples of

everyday conversations in a hospital or healthcare setting, something that I think is quite rare and very much in demand.

Comparing the book to the first edition, it is inspiring to see in text the changes the author makes explicit about her own way thinking and talking about SF. Certain aspects have become more important like making a clear contract with clients utilising questions like best hopes from the work. Also made explicit is the non-verbal development, respecting silence and the client's time, and of talking less from the SF practitioner's point of view. Even as a reader I get the clear sense of an author very much in ease and in control of the process. I felt smitten by the space that was provided for me as a reader. I don't know if this was intentional. It could very well be a by-product of the author's wonderful grasp of SF, the many years of experience and the subtle tone that emerges from someone still learning and passionate about the approach. This is further evidenced by the easy, uncomplicated language, the simple words and all the real examples from real professional conversations.

The book is structured as I can tell in three discernible parts. Chapters one to three lays out the techniques and the thinking associated with SF way of working. Frequently the questions and the techniques are made explicit and given a fresh perspective. The texts are littered with quotes, examples of questions, highlighted key points, nice summaries and case examples. The many case examples reflect work done in health care settings. As a reader I am exposed to many different places and many different types of clients and situations common to health professionals experiences. I really liked how the SF thinking and techniques emerge so nicely from the case examples, not just stopping there but also connecting them to the work of Steve de Shazer, Insoo Kim Berg and BRIEF amongst others. I also liked the way the author chooses to focus in more detail on the assumptions of SF.

Chapters four and five offer full transcripts of two whole conversations. This is a very rich material and it both reinforces the techniques and thinking introduced and discussed in the earlier chapters as well as giving a real sense of context and circumstance to the cases. Both examples show the stance of the practitioner, the interplay with the client and the language used. As before both chapters are punctuated with highlighted key points and the chance for the reader to reflect and make note of important aspects of the approach.

Chapters six and seven extend the work socially looking at and reflecting both the client's and the health professional's work done in networks, with carers and other professionals in a social context. Also client work done with groups is made explicit and discussed as well as SF work done in multi-professional teams. The book ends with an expanded chapter on tools for evaluation like the ORS/SRS, aids for self-monitoring as well as research evidence



collated since the book's first edition.

In summary, this is a timely book and a rewarding reading experience. In a time where time with health professionals is more and more constrained, stress not uncommon and the stakes high for all involved parties, the introduction of well-intentioned SF question could make the difference between a step forward towards hope and resilience or a step towards despair and desperation. Set in this light, I see myself offering this book to countless health professionals in my own network.

### **The reviewer**

Jonas Wells is an English/Swedish anthropologist working as a coordinating manager for something very Swedish, a coordination agency, a governmental body that finances and supports joined-up working between health care, social work, social insurance and job centres. Working both locally in Southern Dalarna in Sweden and nationally with the development of coordination agencies throughout Sweden, Jonas has had great effect using the Solution-Focused approach. Since 2002, when he came into contact with the approach through the work of Björn Johansson and Eva Persson, it has become an embodied practice and a way of life. Currently he is exploring the notion of aesthetics in SF practice, the specific craft of coordination work and the development and implementation of indicators of successful collaboration between the aforementioned public sectors. He also likes to sew 14-15th Century medieval clothes and curates the Solution Focus Playlist on Spotify, (currently 533 songs strong).

Email: [jonas.wells@avesta.se](mailto:jonas.wells@avesta.se)