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CANADIAN SFBT NEWSLETTER

WELCOME

Welcome to the first edition of the Canadian SFBT newsletter. Our goals for this newsletter are ambitious: to continue to build and unite the SFBT community, provide inspirational and provocative interviews with solution-focused experts, book reviews, articles, 'clinical pearls' and upcoming events. Our hopes are that our readers (yes, this means you) will give us feedback as to what they like and what they would like to see different, and contribute by sending us their articles, research, and suggestions. We are very pleased to have as our first interview Dr. Ron Warner, Professor Emeritus at Ryerson University and director of the SFBT certificate program at the University of Toronto. After having such a wonderful interview with Ron, we realized we wanted to share all his amazing wisdom and inspirational words – as a result, it is a long interview. May we also say it is a worthwhile read! We also want to announce that the SFBT conference is being held in Toronto November 6-11th. The quality of the workshops and the camaraderie of this meeting are legendary. Do attend if you can! Please enjoy the newsletter and we would love to hear from you. We can be reached at: Canadiansfbtnews@outlook.com

> OUR ROLE IS NOT AS AN EXPERT ON THE SOLUTIONS TO THEIR PROBLEMS BUT RATHER ON A PROCESS OF ASKING QUESTIONS.
>
> – DR. RON WARNER

WIN DR. WARNER'S NEW BOOK!

Question: According to Ron Warner, what percentage of solution-focused interventions are required for a therapist to be considered a SFBT Specialist?

Send your answers to canadiansfbtnews@outlook.com. The winning entry will be drawn from a pool of correct answers.

INTERVIEW WITH DR. RON WARNER:
From Post-Traumatic Stress to Post-Traumatic Growth

GD: So Ron, we'd like to start by getting a little bit of a bio from you for the readers. I know you are a Professor Emeritus from Ryerson.

RW: That's right.

RW: Yes, and I was actually in the Centre for Student Development in Counselling.

GD: And I know you run the Solution-Focused Program at the University of Toronto, School of Social Work.

RW: Right. I run the counselling one. We have counselling and also coaching and Haesun [Moon] looks after the coaching.

GD: Just to follow up with that, how do you see the similarities and what do you see as the dif - ferences between the counselling and the coaching when it comes to solution-focused work?

RW: That's an often-asked question. It's confusing because the solution-focused model I see as a pure coaching model, and so it really fits in much more with coaching than it does with the mental health model, the medical model. So that's one big point of confusion. In fact, if you watch interviews done, let's say by Peter Szabo, who is an executive coach with no counselling background and makes no pretense to be in the medical mode at all, and when you see his interviews, you would be hard-pressed to tell it from what we do in counselling or therapy. So that's why it becomes confusing. Essentially, though, how I see it at U of T is that people who go into coaching often are interested more in career, work-related, management issues, supervision issues, not mental health issues, put it that way. So that's where some of the confusion comes in. Just because you are a coach you really shouldn't be handling emotional problems. On the other hand, if you take a solution-focused approach, and it does work, you're able to do it, but again that doesn't mean that all coaches by any means should be doing therapy per se. But if you follow the counselling that is the solution-focused model, a lot can be done. When people get really long-term, intractable issues, it's probably not going to work, or it won't work for a lot. So that's one difference. Another, I think, characteristic of this is that coaching is really taking off. A lot of therapists and counsellors are calling themselves coaches. It has status, you're not a head-shrinker, the public is much more receptive to you. It's a status to have a coach, whereas, to have a counsellor is still shameful today. At least most clients see it that way.

GD: That's a really interesting point. Can you speak a little bit more to that - about the status of going to a coach versus going to a counsellor?

RW: Keep in mind my remarks are coming from more recently a context of working in the military and working with trauma.

GD: Right.

RW: So as a result, I'm particularly sensitive to the shame that soldiers feel, and the shame that many people feel when they've been traumatized or something has gone wrong, whether it's an assault, a rape, an accident, or whatever. There is often a huge component there of feeling that somehow they were responsible for it. And so what happens is that when a person feels they need someone to talk to, it's often seen in our society still today as a weakness, and they ought to be able to suck it up and get on with your life, be a man or woman or whatever. There is a lot of stigma there and we're making some strides, but people aren't happy about having to go talk to a therapist or counsellor.

GD: Right.

RW: So there is a lot of stigma there, whereas to go to a coach, because you know we have athletic coaches, and to go to a coach there is status involved in that and it is highly regarded, so life coaches are really taking on a whole new life of their own. Having a coach or a mentor is much more acceptable. In fact, what's happening in Europe now is employers with EAP programs are referring their clients who have absentee problems or are not getting along with colleagues, things that we would normally consider in the mental health realm, are being sent to coaches. And they like it – seeing a coach rather than being sent to see a head-shrinker or whatever is much more acceptable, so we're getting to a cross trend here, in terms of a clear distinction between the two, and it's confused because the solution-focused model, I would argue, is a coaching model. It's goal-directed and it's results-oriented, whereas you could argue that the CBT and other psychology interventions have goals as important, but it's a very different thing from a solution-focused approach where we believe that the clients hold the keys to their own solutions. They need help in getting there, but our role is not as an expert on the solutions to their problems but rather on a process of asking questions.

GD: It makes a lot of sense. Yes, I really love your answer. A little bit controversial too, with the arguing that it is more of a coaching model in some ways, but makes good sense. Two things, one is that I want to go back to your bio and add the military work you've done because that is pretty extensive as well, Ron. So what were you doing for the military?

RW: For three years I worked in the Mental Health Department, a medical model approach, at the Canadian Forces Base in Kingston. Primarily I was involved with trauma, what we call in the military "operational stress injury", which is a really a less stigmatizing term. It's certainly better than PTSD, because it puts it into context. It's the result of stress of war, generally, although it can apply to anything. It makes it more acceptable. What the military has done, as of 2001, is they created what's called OSISS (Operational Stress Injury Social Support). I have been involved with some training of the peer supporters. And my interest is really promoting the awareness of Post-Traumatic Growth through the use of solution-focused conversations and strength-based questions that go beyond mere recovery to being stronger.

GD: Do you train the front-line people in solution-focused skills?

RW: Yes, I just finished a Department of National Defense contract to offer the U of T SFC program at CFB Kingston for the padres, and some civilians were included. This has resulted in the formation of a Post-Traumatic Growth Working Group. So far we have achieved one national military conference presentation, two conference presentation submissions, and one published paper.

GD: Fantastic. That sounds amazing. That sounds quite exciting, which leads us to the next question. How and when did you discover solution-focused brief therapy, Ron?

RW: Way back in the 80's working at Ryerson, I was eclectic, like most counsellors and psych-ologists, as I call it, using just about whatever works. But at that point I started to get interested in doing some private practice and I was very much aware that most clients don't want to come longer-term and I came across a book by Moishe Talmon called *Single Session Therapy* and it had such a ridiculous title I had to buy it. It sounded really interesting but I couldn't accept this idea that you could be helped in one session. That's counter to everything we know, and so I did a little experiment at Ryerson, a paper that got published eventually on this, and we did a follow-up of the clients we saw over a year. We looked at the relationship between the number of sessions they attended and their level of satisfaction. We asked both the clients and counsellors to fill it in, and of course the counsellors felt that the longer they had seen their clients, which ran from one to twenty sessions maximum with an average of 6 or 8 sessions, there was a correlation between the longer they had seen the client, the more satisfied, including helped with the presenting problem and helped with the secondary problems. Well, it didn't turn out that way at all. There was no relationship between the number of sessions and the level of satisfaction. I think roughly a third of those who came for mental health counselling were satisfied with the appointments. Now they weren't as satisfied as those who came for a few more sessions, but anyway what it supported was there wasn't a relationship, and those were the years where we thought short-term therapy was only for adjustment disorders or minor issues, where it's now accepted it's good for just about everything. So from there on I took some training in solution-focused, thought it was interesting. Some of the techniques worked, others didn't. In fact, what the change was, I was teaching a course at the Counselling Psychology Department at OISE and I proposed a course on brief therapy to Mary Alice Guttman, who was the Chair at the time, and she said, "Well, OK." But it was a survey course and I wanted to include all the different branches – even psychoanalysis has apparently a brief version.

GD: Well, Freud was the first one who did a single session.

RW: That's right! Exactly. So she said no, the students have enough theory, let's give them a

course of real practice, and I wasn't happy to hear about this because I knew a lot about a number of different areas, but not much, and I'd taken a little about solution-focused. So I went down to Milwaukee again. I studied and it took me two years before I started to believe that clients could be helped without knowing what the problem is, that I could help someone who was depressed without knowing what was causing the depression. For me, I'm a slow learner, and it took me that length of time to begin to believe in it, and the more I practiced it and taught it, the better I get at it. I'm still learning. So that was my transition.

GD: Wow! And when you went down to Milwaukee did you train with Insoo and Steve?

RW: Absolutely, yes.

GD: And what was that like?

RW: It was great. Insoo was my mentor. I remember her saying to me one time, when you went there on a Friday night at one of their houses and you had wine and cheese, very informal and you got to meet them and I was just sort of starting out and I wanted to travel and she was telling me about travelling here and there and to the far East and I remember her saying to me, "Ron," she said, "You know, someday you'll be going there." And sure enough, I've been there about four or five times now. What she told me came true, so I had lots of opportunities to continue to go back to Singapore, and Kuala Lumpur. She was wonderful. Now Steve, on the other hand, wasn't really comfortable with people. I guess there are people who really like him, and certainly in Germany he was very popular. But in terms of his interpersonal skills... Keep in mind some people like to have distance with their therapist and he had distance, and in carrying on conversations, he rarely looked at you. My guess was this was the early 90's, so it wasn't at the end of his career. Some people loved him, whereas he would be the last one I would ever want to go to if I were having a problem. Whereas Insoo, he admitted that she was a great therapist.

GD: He would say that about her.

RW: Oh yes. She told an interesting story at one of the conferences some years ago - this was after he had passed away - and at that conference, the program committee decided let's break up in small groups and ask what influence did Steve have on you? How did he impact you? And so we broke up and got back together. As we were breaking up she was saying, "Please, please, Steve wouldn't want this. He wouldn't want this." And that's right. He and Insoo did not like to talk about themselves or to get any kind of credit. And so she said, "Let me tell you a funny story." And the story was that it was at a workshop she was giving and someone was coming up from the back of the workshop and someone turned around and said, "You're not welcomed here" more or less. This guy was very plainly dressed with long hair and everything, and she said, "That's Steve!" And then someone else at another time said, "You're not married to Steve," and she said, "Yes, I am". To her that was funny. They were not into social approval or

what other people thought. They were people who had their own values which didn't always coincide with what some people thought, so there was a big difference between the two of them.

GD: And those stories you just said really transfer to the approach. They were really careful...they didn't want it to be a big movement. They wanted clinicians to be paying attention to what the client wants and what the client's goals are. So that humbleness kind of permeates.

RW: Absolutely. I remember when Martin Seligman was... you know Martin Seligman?

GD: Yes, positive psychology.

RW: He didn't start positive psychology, but he formed that group in 1998 and he wanted to make it very different than humanistic psychology and they wanted a strong empirical base. And I was very excited by that and so I rejoined the APA that year because I had been a member before and hadn't found it useful, but when he joined I was excited and I still am about positive psychology. So I wrote to Steve and said "Steve, solution-focused is going to catch on" and so forth, and this is really moving in our direction, and he e-mailed back to me...I wish I had kept it...something about "I don't believe it". And he said if mainstream wants to get on this sort of thing, I'm going to do something else. He wasn't happy about that. Those weren't his exact words but that was the intention there. He didn't believe it and I think he was correct. Now it's starting to happen. It's happening at the grassroots but certainly not in the medical model. Most hospitals and also certainly the military health services are very traditional.

GD: It took two years before you really believed that you didn't need to know the problem to assist a client. So what do you find are the advantages of the solution-focused approach for you?

RW: That's a good question. I don't have to take the responsibility for coming up with a solution. That tends to be very liberating for most people - for most mental health providers, anyway. They're not responsible for that. The challenge becomes how you create the rapport. We can't necessarily relate to everyone, and certain people can't relate to us either as therapists. So what's the advantage? It's not just a bag of tricks. It's really a way of thinking, and I think by educating people, and I'm not talking about professionals, but just the public about the useful aspects of the model. Asking questions, rather than just giving commands about your children if there are any parenting issues or whatever. There's just so much there that will make people's lives better and make it a much richer, human experience. So it's broad-based and applies to just about everything where human interaction is important.

GD: I'm really taken also by this idea of the importance of educating the public. How helpful it can be in their everyday life for parents to ask questions instead of giving commands, is a big, big step. You mentioned how do you create rapport, and we know from the extra-therapeutic factors that this is a big, big piece. Do you think

that solution-focused really lends to forming a good alliance or rapport with clients?

RW: I don't think there's another model that's as good. No question about it. What I like about it is it's not professional. You know, psychologists at least - I can't speak for other professions - pride themselves on being (I have to be careful of my language here) the professional experts, somewhat distant, who does an assessment, thinking the assessment is so important in psychology. Well, I come to think of assessment, except when we're talking about assessment of strength, but that's not what the psychological assessment means, it's really an assessment of weaknesses. Excuse me, I've probably gone a little over the board on this. Moving away from this whole idea of assessment, we knew about this sixty years ago with Carl Rogers. His approach is still being used today. There's no question it does work. There's some big drawbacks, namely it takes a long time because it's not goal directed, but we know that when people just listen it often is therapeutic. And we know from some of the research from single session therapy that the best estimates are that about fifty percent of people who use mental health clinics can be helped in one session. Around fifty percent, or as high as fifty percent. That doesn't mean it's over, but it means they will get enough out of it that they will go on and come back another time when they're stuck again. And I'm really pleased to see these drop-in centres and walk-in centres. My book has been useful to a centre out in Edmonton, calling it a walk-in centre now. It's been going on for several years. They train volunteers to learn these skills and to be available and not to make formal appointments and not to do all the note-taking and record-keeping that we have to do as psychologists, which I don't think is in the best interests of our clients. That's a whole other issue that we could go on here.

GD: Ron, any disadvantages that you've discovered in these years that you've been using solution-focused?

RW: Well, I think one of them might be if you were working with a medical model, you are going to be ostracized, at least raise eyebrows. I remember attending a session called Working in a Toxic Environment. Mental health should be a very positive kind of department, a very positive environment to work, but in my experiences it hasn't been the case. In psychology departments, which tend to be very academic, are not necessarily very humanistic or very friendly. I'm generalizing, of course. There are all kinds of exceptions. So if you are using a solution-focused model, you are going to run into some difficulties with the management wanting a sense of accountability and doing assessments all the time. We know you don't necessarily need to do a full assessment on PTSD to know whether a person has PTSD. It's what needs to happen from that point on, what are the steps he or she needs to take, and of course they have no idea at the beginning of the process of therapy, but it's not based on assessment. This is what Carl Rogers had been saying and more and more professionals. So you are going to be outside of the mainstream.

GD: Yes. Absolutely. We both agree with you there. Ron, what are you excited about these days?

RW: My focus has been on sort of promoting post-traumatic growth because it's not just soldiers in battle who experience trauma, but whether it's a car accident, or assault, or divorce, or whatever, these things are traumatic. How do we help people spring back? We know that the military is very big on what we call resiliency and we know that's important, but resiliency, as I would define it, only means we bounce back to the baseline. And my little message I want to promote is that when you go through a transformative experience, you have the opportunity to be better, to be stronger, but less people know that. Ninety percent of soldiers, for example, know all about PTSD. But less than ten percent have ever heard of post-traumatic growth, knowing it, and how to have even some idea of how to get there. And again, the solution-focused model leads to it naturally.

GD: You know what I really like about it is it pays so much attention to the language.

RW: Exactly. Because we know ideas come from language. And to realize that you can come through this horrible, horrible experience being stronger. I've seen soldiers all the time going through life and death experiences and coming back and being the best fathers, the best husbands, being compassionate, forgiving. All these things happen once one comes into this experience of post-traumatic growth. We have ways of assessing this now, too, which is really encouraging. So that's my mission. That's what I want to do and I'm probably – they have not been confirmed yet – going to be giving a couple of workshops, one in Kelowna and one in Moose Jaw. That's where my son is now posted, which I'm pleased about. So that's what I want to do, is to stay with post-traumatic growth. I'm not doing as much treatment anymore with soldiers. I'm busy enough as it is, so I'm doing more training.

GD: Beautiful. Beautiful. We're really excited about your book that's coming out. When is the projected date?

RW: I wish I knew that. I've asked them to have it ready for SFBTA conference in November. I'm hoping we can get it out by then. The book is really based on what I wrote in 2007 or 8. I wrote a kind of manual for my students and my workshop participants.

GD: Is that the one that's called "Solution-Focused Interviewing"?

RW: That's right. It wasn't well-expressed, but I wanted to get it out for my students. It took me four years to write it. I had to go to Mexico every year just to get away from everything.

GD: That's a nice way to write. Fantastic. We have a copy at our clinic of your book and I have a copy of my own and I think it's an excellent book, Ron.

RW: Excellent. That's the green copy right?

GD: Yes, the green copy. And what I like about it is it really gives the beginner the fundamentals, so it's an excellent book for a developing

therapist, but it's a great reminder for therapists who have been in this field for a long time.

RW: Oh, I'm glad to hear that. That's good. You know because it's so simple in some ways I wonder how helpful it is, but I do get positive reports about it so I'm really pleased about that. I'm delighted U of T Press is going to take over selling it and mailing it out and looking after all that.

GD: Well, Steve DeShazer used to say "keep it simple" and I think that's good advice.

RW: When I was talking about this book almost ten years ago with Insoo, we were in Toronto going to a work shop, I remember her saying "keep it simple...a hundred pages". And I said I never thought of that, for me keeping it that short. It was her suggestion that got me thinking about just writing a hundred pages. I think it's a hundred and fifteen.

GD: And who are you hoping will be interested in the book, or who do you think your best audience will be?

RW: Well, I know they're using it in at least two places as texts. It doesn't have the background. It's not being seen as in the same league as de Jong's and Berg's book at all. The *Interviewing for Solutions* – that's the bible. I had to explain to the U of T Press when they asked me these kinds of questions for the reviewers. It's not in that league. It's primarily very basic. I've written it hopefully for people who are not professionals who can also understand it. So I hope it's a book that's useful. It's not certainly a theoretical book or an academic book. But there's just so much opportunity for OSISS workers and volunteers and others who are helping others, and I think that's where I'd like to see mental health go. I'd like to see more social workers and psychologists being consultants to volunteers because there's much more help needed out there than we can possibly give and I think the role for many registered psychologists and social workers is to be a consultant to those who are going to be doing more front-line work.

GD: Nice. Very nice. Anything else you'd like to say about the book?

RW: I hope it's useful.

GD: Well, you know, we've given it to students at our clinic, many students, who have really enjoyed it. Because, you know, you called it a primer and that's what they want, especially graduate students. They want something that they can start to get the ideas and the way you have divided the book as well, you know you've got the tri-phase, and I think you make it very understandable for the public and students and I think you should be commended for that. I think it's a great book and I'm glad it's going to be a wider publication, so congratulations.

RW: Well, thank you again.

GD: So now we'd like to talk a little bit more about your certification program because we're thinking that readers of the newsletter, may have an interest or curiosity in it. So for the people who may have an interest, I think your program that you offer at the University of Toronto is such an opportunity. When did you start the program?

RW: I have trouble remembering whether it was 1998 or 1999. My first graduating class, I believe, was in 1999, or it might have started in 1999 – that's why I get confused. I can't remember if the first class started in the fall of 1998 or the spring of 1999.

GD: And how did you get the idea to have a certificate program?

RW: The reason for starting the program, my rationale, is that many people would take a workshop or two in solution-focused and say that they were solution-focused, and certainly they could ask their clients solution-focused questions such as the miracle or exception questions and they would work, but if you watched what they were doing, had an opportunity to read a transcript or see them in action, you would notice that maybe 70 percent of the time they were problem-focused.

GD: Right. Yes.

RW: So we saw that students, just by taking a two-day basic skills, could use the model, and they could call themselves solution-focused and employers didn't know the difference. If you study it and say you're doing it, they accept it. So the idea behind the program was to raise the level, raise the bar to a point where people could be what I call the specialist level. It doesn't mean you can't use other models but what we say to students in the program is wait until you do the program, wait until you can demonstrate you can conduct a solution-building interview, and once you can do that if you want to incorporate some of the other models, fine, but you really need to know the basics. And the other models you incorporate really need to be from a strength-based, solution-focused perspective. I will say that last point is a little controversial within the solution-focused community because there are those who would argue, the leaders, that the solution-focused model is enough, that you don't need to know anything else. And I believed that until I went to the military. In my clinical practice I had the occasional, usual number of traumas and I had taken EMDR training at the time, and I said well if someone doesn't respond in two or three sessions I would have this as a fall-back. I was down in Milwaukee, and Joanna Uken, who has done wonderful work with domestic abuse treatment in California, was up taking the training with us and she was saying to us one evening that she has also learned EMDR because she thought it could be a complementary kind of thing, and some of us, I don't know if it was me or someone else said "Well, have you raised this with Insoo?" And she looked at us and said, "Insoo wouldn't want to hear that." She said she didn't feel comfortable in raising that and we said fine, but would you show us? And she showed us a little demonstration and I thought this could be a really useful skill and so I went and took level 1 training. But in my clinical practice at Ryerson, the number of opportunities I had were not that great for trauma cases. It's not like a saw one every week, trauma cases, but when I did, I was able to resolve it just with the solution-focused model, or they didn't come back so I never had the opportunity. In fact, my

position has been if someone doesn't respond by the second or third session, the first referral I make is to EMDR because I think it's an effective program and it's short and brief and although it's not strength-based, it's good. Where was I going with this?

GD: That solution-focused can be integrated with strength-based approaches.

RW: And I say this in keeping that it needs to come from a solution-focused perspective and I would argue this can only happen after a person has had adequate training or has the skill level. I have a colleague of mine, a dear friend who's a psychologist, and he considers himself solution focused and he's not. He calls it solution-oriented, which is sort of, what's his name...

GD: Bill O'Hanlon?

RW: Yes. I don't know much about O'Hanlon's work so I'm not commenting on that, but people who are really eclectic and throw some solution-focused into their treatment don't qualify, in my view anyway, as being really solution-focused. They don't reach the threshold, and the average threshold I have set for the clinical case presentation and TCPC is 70 percent of an interview ought to be strength-based, solution-focused interventions. There's still room for using other models but again you'd use them from a strength base. I guess Steve and Insoo were a little concerned it would be a little watered down, and maybe that was a legitimate at one point, but I don't think so now. I think we need to be... Now as I'm saying this, I realize some people may interpret this as eclectic is the way to go, or even 51 percent solution-focused and I would define it as excess of 70 for the specialist level. Most solution-focused specialists, as I call them, have 80-90 percent of their interventions are solution-building and not problem-focused. To be a solution-focused specialist, as I call it, you've got to be in that ballpark: above 70 percent. And you've got to see their tapes. That is so important. The world of difference between what people say they practice and what they actually do.

GD: Absolutely. And we tape here quite regularly and it really keeps us sharp, watching our own tapes or even sometimes listening. If we don't tape, we audio tape, so that's been very, very handy.

RW: That's the way to grow and I think part of the new generation of therapists. You know, my generation didn't grow up as comfortable with taping. We don't like to tape and we think supervision really is only for students – that once you're a professional, you really don't need it. Whereas the European model is for every so many hours you need to have a supervisor outside of the workplace and I think there's a lot of merit to that. And part of that is taping and viewing what you're doing. But there's a lot of resistance to that.

GD: And I know that this year your certificate program has a new module and it's Solution-Focused Supervision with Heather Fiske who has also written an excellent book called *Hope in Action*. That's wonderful. Well, I think we've just had a delightful conversation with you and

we thank you so much for spending some time with us.

Dr. Ron Warner

Calendar:

Upcoming Events not to be missed:

Please circle your calendar! The Solution-Focused Brief Therapy Association's Annual Conference will be held in Toronto, Ontario, November 6th to November 11th, 2013. For Solution-Focused aficionados this conference is not to be missed and we are fortunate that it is right here in Canada. The camaraderie and quality of the workshops and talks are legendary. For more information, please go to www.sfbt.org/2013.html

The University of Toronto, School of Social Work provides Solution-Focused Counselling and Coaching training. The Counselling options for fall 2013 are: **Crisis Intervention:** Friday, October 18th to Saturday, October 19th. **Group Applications:** November 15th to Saturday, November 16th. **Couples and Family:** Friday, December 6th to Saturday, December 7th. For more information please go to: www.socicalwork.utoronto.ca/conted/certificate/SFC.html

Solution-Focused Brief Coaching: October 4th and 5th. **Solution-Focused Training Methodology:** November 1st-2nd.

Book Review:

Solution-Focused Supervision: A Resource-Oriented Approach to Developing Clinical Expertise By Frank Thomas

This is a must-read for Solution-Focused Supervisors and anyone who enjoys working with the SF approach. Dr. Frank Thomas is a Professor of Counseling and Counselor Education in the College of Education at Texas Christian University in Fort Worth, Texas. Thomas is also a licensed Marriage and Family Therapist and LMFT-Approved Supervisor. With over 35 years of experience he is well-qualified to write a book on SF supervision. His 35 years plus experience in the field is very evident in his latest work.

Dr. Thomas is meticulous with details, expertly referencing supporting research and material, defining what makes something SF, and the appropriate stance necessary. The book approaches supervision from a systemic perspective and focuses on the isomorphism inherent in supervision. Thomas supplies the reader with many tools, such as forms he uses to enhance the supervisory process, and helpful questions and transcripts that bring supervision to life. I found the chapter on self-supervision brilliant. Dr. Thomas states that SF looks at what works and does more of it. This book is testimony to that stance - it is inspirational and informative. Developing Supervisors will find it invaluable, experienced Supervisors will find it an excellent refresher and validating of the SF approaches they already use. I would also

recommend this book to anyone who calls SF their paradigm and preferred way of working.

Clinical Pearls:

I met with this very adorable boy and his mother at our walk-in clinic on 2 separate occasions; once when he was 4 years old and again when he was 6. Out of the mouth of a 4/6 year old came these wonderful gems to remember:

- Never under estimate the value of extra-therapeutic factors, even those during a session. When we were in the middle of our first session, after talking about how behaviours rarely get out-of-control when he and his mother have hug times, the fire alarm went off in the building and we needed to evacuate. This little fellow became so excited when he saw the fire trucks and firemen run out and got more excited when he saw police officers come down the street on horseback. My frustration of being interrupted by the fire alarm changed as I watched how he and his mother talked about how firemen and police officers are such amazing helpers. They then began talking about how he is such a big helper in the home. He bragged about how he helps put Avon stickers on the Avon books for his mother and how likes doing things with his grandpa as well.

- Often, the solution has very little to do with the problem. The issue of concern in therapy was this little fellow's behaviour. After the second session, the final remark, as we parted ways were: "We sure had a nice chat, but you did nothing for my behaviour." Our exception talk while playing Jenga, which lasted an hour, revealed how behaviours were never a problem when he fished with his Papa, watched TV with his parents, had snacks with his grandmother, had Friday night video games with his entire family, and when he went to school. Mom called me several weeks later stating that the behaviours were much more manageable because everyone was enjoying together time.

- Clients, no matter how old they are, have the resources, strengths, and ideas for what is helpful. After playing compliment and exception Jenga, he told me that the next time I see a boy like him, I should play a different game to get the answers I needed. He suggested that boys like him want to be more active than just sitting around playing a game or talking. He recommended this game: People stand in a circle and someone starts the game by tossing a ball to a person and the person who catches the ball gets to say what they appreciate about the person who threw the ball to them. He thought that playing the game this way would help people in families talk more about what they appreciate and that would probably help with their behaviours.

Submitted by: Geri VanEngen

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