

## **First session solution-focused brief therapy with families who have a child with severe intellectual disabilities: mothers' experiences and views**

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This exploratory paper aimed to shed light on the experience of first session solution-focused brief therapy (SFBT) for families who have a child with intellectual disabilities (ID). The therapist interviewed the participants, all mothers, two weeks after their initial session. The Helpful Aspects of Therapy Questionnaire (Llewelyn, 1988) was used with structured recall (Elliot and Shapiro, 1988), a procedure in which participants listen to excerpts from their therapeutic sessions identified by them as helpful or unhelpful. Interview transcripts were analysed by the therapist using interpretive phenomenological analysis (Smith, 2003). Three superordinate themes emerged from the interviews: (1) SFBT brought to mind the idea of 'making the best of it'. (2) Examination of wishful thinking. (3) Therapeutic relationship. In addition, self-efficacy recurred as a sub-theme throughout. The 'miracle question' was perceived as irrelevant by the mothers and was the most frequently cited unhelpful event. It also seemed to be associated with shifts in wishful thinking. These mothers' experiences suggest that SFBT is a useful structure for first sessions particularly as it seems to build a useful therapeutic relationship, highlights self-efficacy and may encourage helpful coping styles.

### **Introduction**

Systemic therapy is increasingly used with families who have a member with intellectual disabilities (ID) (Fidell, 2000; Frankish and Terry, 2003; Vetere, 1993). In turn solution-focused brief therapy (SFBT), an approach associated with and popular within family therapy (Lee, 1997; Letham, 2002; Wheeler, 2001), is also beginning to be explored in ID services. SFBT has been adapted for individuals who have mild ID with some success (Bliss, 2002; Franklin *et al.*, 2001; Smith, 2004; Stoddart *et al.*, 2001; Thompson and Littrell, 1998).

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However, less is known about the use of SFBT with families who have a child with severe ID.

An automated and systematic literature review found one case study using SFBT with paid staff caring for an adult with severe ID (Rhodes, 2000). The practitioner found it a useful approach; in particular the focus on strengths, the non-blaming stance and the way carers generated solutions that built on their competencies. This encouraged the authors to explore the use of SFBT with families caring for their child with severe ID. This was undertaken in the form of two related projects. The first (Lloyd and Dallos, 2006) examined the content and process of initial SFBT sessions with seven families who had a child with severe ID. It represented the practitioner's perspective, in a similar way to a case study, although for ease of reading the seven cases were collapsed into themes. A thematic analysis of these initial sessions indicated that SFBT highlighted parents' competencies, goals and achievements. Questions about coping shifted conversations from problem-dominated discourses to ones of resilience and strength. The 'miracle question' prompted a change in rapport and discussions about the child becoming 'normal' with the acceptance of the improbability of this. Initially a vague vision of a preferred future emerged that became more specific. Alternatives to the 'miracle question' yielded fuller replies. Processes of empowerment, considering possibilities and understanding the child's abilities emerged in sessions. Difficulties were encountered when a child with autism, who participated in part of a session, made extremely literal interpretations of some questions.

This, the second part of the exploratory project, followed up the same families two weeks after the initial SFBT session. It aimed to explore the participants' perspectives of the initial sessions. This is congruent with the SFBT stance of treating clients as experts on their own situations. It is also consistent with British government objectives to involve service users as collaborative partners in the development, delivery and evaluation of services (Department of Health, 1999, 2001a, 2001b). To place the study in context, an outline of SFBT is presented with research on users' experiences of it. Alongside is a summary of the literature on what parents caring for a child with ID find helpful.

### **Solution-focused brief therapy**

The development of SFBT is usually attributed to a group of practitioners including de Shazer and his colleagues (de Shazer,

1985, 1988; de Shazer *et al.*, 1986), who studied and drew ideas from the Mental Research Institute of Palo Alto, California (de Shazer, 1982). O'Hanlon and Weiner-Davis (1989) were also integral to the development of SFBT. It is a way of working grounded in practitioners' experience rather than a theoretical model. SFBT has continued to develop and certain components have been dropped or emphasized in response to feedback (e.g. de Shazer, 1997; Miller and de Shazer, 2000). The Brief Therapy Practice in London, among others, has disseminated the approach in the UK (e.g. George *et al.*, 2003). The approach aims to shift attention to the life the client would like to lead rather than examining problems. The core assumptions of SFBT and elements of sessions are detailed by Beyebach (2000), George *et al.* (2003), Rhodes and Amjal (1995), and summarized in Tables 1 and 2.

Gingerich (Gingerich and Eisengart, 2000; Gingerich, 2001) has reviewed outcome studies of SFBT and concluded that it is as effective as other interventions. However, there are few outcome trials of

TABLE 1 *Elements of SFBT interviewing*

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1. *Language*: reflects the idea that problems and solutions are subject to perceptions and open to change.
  2. *Problem-free talk*: enquiries about areas of the person's life that illustrate competence and strength.
  3. *Exceptions*: curiosity about times the problem is absent, coped with or less intense.
  4. *Goals*: detailed, specific, realistic, observable goals are elicited from the client.
  5. *Hypothetical future*: The client's vision of their preferred future is elicited in a variety of ways. De Shazer (1988) designed the miracle question for this purpose. 'Suppose that one night when you were asleep there was a miracle and this problem was solved. The miracle occurs while you are sleeping, so you do not immediately know that it has happened. When you wake up what are the first things you will notice that will let you know there has been a miracle?'
  6. *Rating scales*: the client is asked to position him/herself on a scale where one represents the worst things have ever been and ten represents the best things could be. Questions are asked about how they got that far, what is preventing them from dropping down the scale, how they would know that they had reached a slightly higher point on the scale and to visualize this. Variations on this theme are used.
  7. *Tasks and compliments*: The therapist may take a break to formulate. Compliments are observations of exceptions, strengths, resources and motivation. Inter-session tasks are tailored to the client and include observing exceptions, doing more of what works or doing something different from usual when the problem arises.
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*Source*: Summarized from Beyebach (2000), George *et al.* (2003), Rhodes and Amjal (1995).

TABLE 2 *The core assumptions of SFBT*

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1. Problems are subject to an individual client's perception and interpretation.
  2. An emphasis on the past and details of the problem are not essential.
  3. There are occasions when problems are less or absent (exceptions).
  4. Practitioners believe that clients can make changes.
  5. Small changes can have an important impact.
  6. Resistance is not a useful concept; clients cooperate in different ways.
  7. The client's goal is central.
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*Source:* Summarized from Beyebach (2000), George *et al.* (2003), Rhodes and Amjal (1995).

sufficient quality. The majority of the SFBT literature comprises case studies and practitioners' reports of using it with a wide range of client groups (see Miller *et al.* (1996) for examples).

The 'miracle question' (see Table 1) has become a signature of SFBT and is included in the European Brief Therapy Association research definition of SFBT (Beyebach, 2000). It is also perhaps the most controversial part of the approach. It is potentially highly sensitive and difficult to understand for some people. Instead many practitioners choose to ask about a 'preferred future' (e.g. Stoddart *et al.*, 2001) with clients who had mild ID, and Neilson-Clayton and Brownlee (2002) with cancer patients. Conversely there is a widely held view that provided language is subtly adapted and there is a supportive therapeutic relationship, the question is useful (de Shazer, personal communication, 2003; McKeel, 1996). Butler and Powers (1996) used SFBT in bereavement counselling. They suggested that it is a means of acknowledging clients' aspirations and grief while encouraging them to consider possibilities for the future and to take some control. Curious about this debate, the authors decided to ask families caring for a child with severe ID for their views on the miracle question.

### **Users' views of SFBT**

It cannot be assumed that clients and practitioners agree about what happens in therapy and what is helpful. Metcalf's (1996) adult clients thought that the practitioner took an educational role and made suggestions. In contrast the practitioners perceived that they elicited solutions. Parents in Lee's (1997) study of SFBT in a child and adolescent mental health setting also perceived the practitioner in an educational role; they valued useful feedback and education. They also reported that SFBT helped thinking and that they valued the support, validation, positive focus and goals. The parents less

frequently reported unhelpful aspects of SFBT but some voiced criticisms that the therapy was rigid, artificial, too positive, insensitive and unsupportive. This echoes the criticism that SFBT can appear to be solution-forced therapy (Nylund, referred to in O'Hanlon, 2003).

Metcalf *et al.* (1996) found that practitioners and clients shared several positive perceptions of SFBT. These included reinforcing strengths, listening and focusing on the client. Students with mild ID reported that questions asked in the course of SFBT changed their thoughts, affect and behaviour, and they perceived the practitioner as expert, trustworthy and attractive (Thompson and Littrell, 1998). In the context of recovery from a stroke, Tollinton and Tollinton (1996) and Tollinton (1999) reported on the value of O'Hanlon's stance of recognizing exceptions and achievements that contrasted with the 'demoralizing usual rehabilitation approaches'. They welcomed the hope inherent in being open to possibilities while not denying the reality of the disability. On the other hand, Saetersdal (1997), a therapist and mother of a young person with a disability, and Rolland (1997) expressed concern that interventions which highlight positive possibilities can inadvertently romanticize the experience of disability and bury suffering; particularly in a culture that values perfect health and avoids death, illness and loss. This raises the question of 'What do parents, caring for their child with ID, want and find helpful?'

### **Parents caring for a child with ID**

Parents who have a child with ID report that caring can be a positive experience, gratifying and personally enhancing (Grant *et al.*, 1998; Hastings and Taunt, 2002; Hastings *et al.*, 2002). They want this to be acknowledged and suggest that a vision of a promising future helps to create a sense of control over family life (Knox *et al.*, 2000). They also point to negative experiences, when services have failed to acknowledge grief or have lacked sensitivity to demands on the family and their stage in the life cycle (Bruce and Schultz, 2002; Grant and Ramcharan, 2001; Grant *et al.*, 2003; Shearn and Todd, 1997). Parents have stated that they value collaboration, i.e. services and interventions that share decision-making with them, and respect their views and expertise (e.g. Cunningham and Davis, 1985; Knox *et al.*, 2000). They also value listening, empathy, directness and information (Pain, 1999; Sebba, 1989; Witts and Gibson, 1997).

SFBT may have the potential to be useful for families caring for a child with severe ID. Experienced clinicians have found it useful with

a variety of client groups. Many of the components of SFBT tally with factors these parents find helpful; for example, a focus on the positive aspects of caring, and a vision of a promising future. It aims to be collaborative and to respect parents' expertise. However, there are areas of concern; outcome trials are limited, the literature focuses largely on practitioners' views, and SFBT may be insensitive, overly positive and fail to offer information.

This exploratory study aims to gain an understanding of service users' experiences of initial SFBT sessions, specifically what they find helpful, unhelpful, and their views on the 'miracle question'.

## **Method**

### *Context*

The study was conducted in a National Health Service clinical psychology department for people with ID in a region of England with a predominantly white British population. It covers rural, suburban and inner city areas; the latter has Employment, Health and Education Action Zone status indicating deprivation. Ethical approval was obtained from the Local Research and Ethical Committee. Parents gave informed consent and assented on behalf of their children. Participation and non-participation in the study did not affect the subsequent service delivery. As an exploratory study small numbers of initial sessions were studied to minimize any unforeseen unhelpful effects. Each SFBT session was designed to stand alone. After the initial SFBT session parents were offered treatment as usual, with choice about the type of input.

Families who use the service are experienced users of special education, social and health services, including psychology. They receive government carer's and disability allowances indicating the severity of their child's ID. The referral to clinical psychology was part of a broader ongoing package of care provided by a range of professionals and agencies.

### *Design*

Considerable thought was given to who should interview the parents about their experiences. Whoever did so would ask questions, elicit responses and analyse the replies with their own particular bias. Inevitably the mothers and interviewer/researcher would co-construct an account of what occurred in the session. A decision was made to

take an ethnographic position, i.e. the first author conducted the SFBT session, subsequent interview and analysis. The aim was to capture the detail of the data as closely as possible (Robson, 2002) from those who were there, with a bias that was understood and acknowledged. To achieve this as rigorously and transparently as possible interpretive phenomenological analysis (IPA) was used.

IPA is a qualitative approach designed to achieve an in-depth understanding of experience (Smith *et al.*, 1999; Smith, 2003). It was developed in health psychology but is increasingly used in other arenas (e.g. Osborn and Smith, 1998; Knight *et al.*, 2003). IPA attempts to describe and understand participants' subjective experiences (phenomenology) but recognizes that in doing so the researcher is inevitably engaged in an interpretive process. Although starting with an analysis of an individual's experiences the approach attempts to draw out themes shared by participants, while also taking into account differences and unique aspects of their experience. Validity enhancement measures such as an audit trail, inter-analyst comparison, a reflexive analysis diary and presentation of direct evidence such as quotations from the participants were included in line with quality standards for qualitative research (Elliot *et al.*, 1999; Stiles, 1993; Turpin *et al.*, 1997).

### *Procedure*

Each family received an initial appointment of approximately one hour using SFBT, as outlined in Tables 1 and 2 (George *et al.*, 2003), and detailed in Lloyd and Dallos (2006). In line with SFBT protocol the families chose who attended. Mothers attended all of the initial sessions. One father, a maternal grandmother and two of the children with ID participated in parts of them. All participants were invited to meet the first author/therapist again two weeks later to discuss their experiences of the session in a research interview; only mothers came forward.

A semi-structured interview was conducted based on The Helpful Aspects of Therapy Questionnaire (Llewelyn, 1988; Llewelyn *et al.*, 1988) with additional questions about the ethnographic design and the 'miracle question' (see Table 3). Care was taken to avoid eliciting responses and leading questions. Structured recall was used, a technique whereby the mother was asked to recall the most helpful part of the SFBT session. This was then located on the session audio-tape (or transcript for two participants who were reluctant to hear themselves on audio-tape), listened to and discussed (Elliot and Shapiro, 1988). This was repeated for all questions in Table 3. This

TABLE 3 *Interview topics*

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1. To recall the session in general and their experience of it.
  2. Identify the most helpful event and discuss why.
  3. Identify the least helpful event and discuss why.
  4. The miracle question (if not already discussed).
  5. How they felt in the session.
  6. How the interview would have differed if someone else had conducted it.
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*Source:* Adapted from Llewelyn, 1988; Llewelyn *et al.*, 1988.

research interview was also recorded on audio-tape, transcribed and identifying information changed.

### *Participants*

All families on a waiting list (one week to four months) to consult with a clinical psychologist, in the ID service described above, were invited to participate in the study regardless of the reason for referral. They all had a child with a significant ID less than 18 years old. Of the thirteen families invited seven chose to participate. The clinical psychologists in the department considered them similar to those routinely using the service. All had seen a clinical psychologist or psychiatrist previously about their child. Three parents had been treated for stress or depression. One mother and child shared a degenerative physical condition.

Only mothers ( $n = 7$ ) volunteered to take part in the research interviews. A father engaged for parts of the initial session and subsequent research interview. A decision was made to exclude his partial contribution for a sample that had experienced the whole session. Demographic information about the mothers is presented in Table 4 in a group format to preserve anonymity.

The children's ID ranged from moderate/severe (1), severe (4) and profound (2). Their diagnoses included global developmental delay with hypotonia (2), autism (2), congenital brain damage (2) and Down's Syndrome (1). Two of the children were not ambulant, two did not have any speech and the remainder had communication difficulties. Reasons for referral included sleep problems, smearing, inappropriate sexualized behaviour and behaviour management, but all had a wider range of issues they were dealing with; for example, fighting for an educational placement or whether to have another child.

### *Analysis*

Analysis began after all the data had been collected and following an initial reading. Non-verbal data noted during the actual interview also

TABLE 4 *Participants' characteristics*

<i>Mean maternal age</i>	41 years (range 31–54)	
<i>Ethnicity</i>	British Caucasian	7
<i>Family structure</i>	Two-parent	3
	One-parent	2
	Blended	2
<i>Residence</i>	City	4
	Town	2
	Rural	1
<i>Maternal employment f = full-time p = part-time (partner's employment where applicable)</i>	Professional	3 (2)
	Skilled/manual	f = 1 p = 2
		2 (3)
	Full-time mother	p = 2
	2	
<i>Mean number of children</i>	2.4 (range 1–5)	
<i>Age of referred child</i>	8 years (range 4–14 years)	
<i>Gender of referred child</i>	Boys	6
	Girls	1

informed the analysis. The fullest account was selected and reread several times. Points of interest or significance and emerging themes were noted as concise phrases that captured the essential quality of the text. These were clustered together as connections between them became apparent as sub-themes. Clusters of sub-themes that appeared to most strongly represent the respondents' concerns became superordinate themes. The process was repeated for the remaining transcripts and earlier transcripts were reviewed in the light of any new themes. In an iterative process the themes were repeatedly checked against the mothers' accounts.

#### *Checks on the integrity of data analysis*

- 1 An undergraduate psychologist, independent of the study, repeated the entire analysis and the second author/supervisor analysed the fullest transcript. They drew comparable themes from the transcripts, although their choice of words sometimes differed.
- 2 In a similar process the findings were discussed with the SFBT practitioners who had authenticated the initial session transcripts.
- 3 All of the participants were posted a summary of the findings and then given the opportunity to comment by post or in person. One participant and a member of a parent support group, independent of the project, discussed the findings in depth and commented on a

final draft of the paper. Other participants made brief comments. Any differences in interpretation were resolved by a re-examination of the transcripts and discussion until a consensus was reached, with deference to the participant.

- 5 Findings were also presented to groups of clinical psychologists and practitioners in ID services independent of the project. Journal referees and university staff marking the project added further reflections that were integrated into the final text.
- 6 A reflexive research journal and audit trail were kept and discussed in both individual supervision and qualitative research group supervision. This demonstrated that the line of argument was supported by the data and research process.
- 7 Openness about the authors' positions.

### *Therapist/researcher's stance*

The first author was the therapist in the initial sessions, conducted the interview and analysis and led the write-up. I am a mother (of children without disabilities) and a British clinical psychologist, with eighteen years' experience in ID. My clinical background is learning theory and advanced training in SFBT from the Brief Therapy Practice. I have used SFBT for four years with supervision. I am curious about the relevance of SFBT for families who have a child with ID. The second author provided supervision for all stages of the project. He is an experienced family therapist and researcher with an interest in attachment, eating disorders, adolescence and qualitative research.

## **Findings**

Three superordinate themes emerged from the mothers' reflections about their initial SFBT sessions.

- 1 SFBT brought to mind the idea of 'making the best of it';
- 2 examination of wishful thinking;
- 3 the therapeutic relationship.

Each superordinate theme comprises a number of sub-themes. The sub-theme of self-efficacy recurred in each superordinate theme. The mothers' experiences are summarized in Table 5. The superordinate themes and sub-themes are then described with illustrations from the mothers' accounts.

TABLE 5 Themes emerging from the mothers' accounts of their SFBT session

<i>Super-ordinate themes</i>	<i>1. SFBT brought to mind the idea 'making the best of it'</i>	<i>2. Examination of wishful thinking</i>	<i>3. Therapeutic relationship</i>
<i>Sub-themes</i>	1.1 Acceptance of issues outside their control (e.g. disability).	2.1 Miracle question perceived as irrelevant and confusing.	3.1 Time to think.
	1.2 A belief that one can choose how to appraise disability.	2.2 Belief that change is created by one's own efforts.	3.2 Hopeful comfortable relationship.
	1.3 A focus on issues in the present and immediate future.	2.3 Covert hopes for a miracle.	3.3 Expectations of directive expert not realized.
	1.4 Feelings of self-efficacy and self-worth.	2.4 Self-direction and efficacy instanced.	3.4 A collaborative relationship. 3.5 Existing relationship the preferred context for involvement in research.

*1 Superordinate theme: SFBT brought to mind the idea 'making the best of it'*

A stance of 'making the best of it' emerged in all seven accounts. It is defined below.

'There's no point in dwelling on it [disability], we are where we are, it's getting on with it, trying to make the best of it, he's come so far and done so well and it's keeping it going.'

(Tina)

*Sub-theme 1.1 Acceptance of issues outside their control.* The mothers perceived that there was no choice about the actual disability or the role of carer. For two mothers this was due to the tie of kinship.

*Sub-theme 1.2 A belief that one can choose how to appraise a situation.* However, the mothers strongly believed that they could choose how to appraise their situation. This included an idea that perceptions can change and are within the mothers' control.

'You are just dealt a hand of cards and you can either go round thinking "oh my god life's awful" or you can make the best of it. So I always try and make the best of it.'

(Alison)

*Sub-theme 1.3 Focusing on issues in the present and immediate future.* The mothers did not want to 'dwell' on the disability and the past that could not be changed but looked to the future and the choices it held. SFBT, because it was congruent with this position, was contrasted favourably with other approaches (it was not clear if these were psychological or other, e.g. physiotherapy).

'With any professional you meet you have to go back and start from square one, explaining you know what's your diagnosis and you know what happened . . . it can be a real problem going over all that which I don't always find helpful. I just think this is where we are, where do we want to get to and how do we get there or something like that.'

(Jane)

This view is consistent with the most frequently stated helpful events, the scaling exercise and detailing a hypothetical preferred future. Two of the mothers described how they adopted and visualized the scale between sessions. The mothers felt that the scaling task acknowledged difficulties and a sense of hope by drawing attention to exceptions and the future.

'It [scaling] was immediately useful in making me realize that although I was feeling at 1, there had been times when I had been as high as 4 or 5 . . . it made me remember that times would be better again.'

(Emma)

*Sub-theme 1.4 Feelings of self-efficacy and worth by reflecting on achievements.* Six of the mothers perceived their achievements and skills positively with feelings of self-efficacy and worth.

'He's made me a better person, he's made me realize I can do things that I thought I can't. He's where he is now, because when he was a baby,

mum and me did all that physio, taking him to the hospital and all the doctors and portage. No not grief, he's helped me to be a stronger, better person. To fight.'

(Tina)

However, one mother did not share the enthusiasm for focusing on her skills; doing so seemed incongruent with her self-image.

'The most unhelpful bit for me was telling me that I'd got skills that I am using because I don't feel I've got any skills. I'm just trying to do what a mother does.'

(Jenny)

## *2 Superordinate theme: examining wishful thinking*

The participants grappled with two conflicting ideas: (1) that the disability was permanent (sub-theme 1.1) although the mother could influence changes in behaviour and their perception of it as described above and (2) wishful thinking, i.e. hoping that an external agent would create change.

*Sub-theme 2.1 The miracle question perceived as irrelevant or confusing.* All the mothers found the miracle question irrelevant or baffling. Five stated that it was the least helpful event. The problem centred on the word *miracle*. One, an active Christian, explained that miracles had different connotations for her. Another did not hear the question fully. She made the following comment on hearing the session audio-tape.

'The question you put it to me was better than I thought you put it to me. I just remember you saying if she woke up and everything was alright . . . I couldn't see the point of that, why ask that? Because it's never going to happen is it? It doesn't upset me because I know she'll never, but I just couldn't see the point of it.'

(Cathy)

A distinction was drawn between the perceived irrelevance of the miracle question and the value of imagining a hypothetical future.

'The bit [most helpful event] where you asked me what it'd be like in the morning and I told you what I'd like it to be like . . . imagining it in little bits, making it real and one step at a time.'

(Tina)

*Sub-theme 2.2 Belief that changes are created by one's own efforts.* A belief that change usually came about by the mothers' own efforts emerged. The perception of self-efficacy brought about a range of feelings, empowerment, astonishment, disappointment and endurance. In four of the accounts the conversation switched from miracles to magic.

'it made me feel like you know "yeah I can do this" although it might be hard, but . . . perhaps there isn't any magic wands, I've just got to plod on doing what I'm doing . . . and when things get tough talk to somebody. That's what I took away.'

(Alison)

*Sub-theme 2.3 Covert hopes for a miracle.* A covert hope for a miracle to cure the disability emerged in six of the accounts. The non-verbal behaviour and one mother's comment in the participant validation exercise suggested that a covert wish that sustained hope had been exposed.

'It was kind of oh if I speak to [psychologist] she'll have a miracle cure for that, [*pause, nervous laugh*] but you know, it's not the case.'

(Jess)

'I believe in Christian miracles and I'm kind of thinking "hey should I actually say that I do believe in miracles" . . . I felt uncomfortable, but I didn't want to voice that, because I thought, well you know, some people even start on about God, as they say . . . it's a bit odd.'

(Jane)

One mother who validated the findings and one participant said they were proud of their children and loved them as they were. They said the miracle question took them back to the initial diagnosis and conflicted with the position they now held of acceptance.

*Sub-theme 2.4 Self-direction and efficacy instanced.* The mothers' accounts were interspersed with instances of being responsible for change rather than an external agent or 'miracle' exemplified by mothers stressing the word 'I'. This was interpreted as SFBT being experienced as a reminder of their ability to create change or a stimulus.

'I'm beginning to realize that perhaps his screaming is a ploy . . . rather than the fact that he really is upset, I think I've got to suss out the difference.'

(Emma)

*3 Superordinate theme: therapeutic relationship*

*Sub-theme 3 Time to think.* The SFBT session was experienced as a useful time to think, apart from the demands of caring and family life, although this could apply to any therapeutic approach.

'I thought it useful to think about things in a certain way, or even to speak about them because normally I just carry on, just letting things happen but without necessarily thinking about how I can sort it out or approach it.'

(Jane)

*Sub-theme 3.2 Hopeful and comfortable feelings.* All the mothers reported that the therapeutic relationship was comfortable. One mother acknowledged that her problem had not been solved but she felt hopeful.

'Very comforting to be in the home environment, very easy to chat to you . . . I did feel that your relationship with me and Grant will help us to find more strategies for coping with his problems.'

(Emma)

*Sub-theme 3.3 Expectations of a directive expert not realized.* When advice or a suggestion was made the mothers valued it highly. Three mothers were disappointed that their expectations of the psychologist as a directive expert were not realized. This echoes the covert hope for a miracle cure and one mother's self-perception as a non-expert.

'I thought that you would come up with more ideas. I thought that's why we were there to get ideas. I know we got one but I thought there would be more.'

(Cathy)

*Sub-theme 3.4 Collaborative relationship.* All the mothers seemed to experience a collaborative relationship in which they shared agency, expertise and ownership of the plan with the psychologist.

'It sounded such a good idea something we could do actually straight away without having to kind of go out and buy something or go and talk to someone for hours . . . the whole thing is about working towards a solution together isn't it?'

(Jane)

*Sub-theme 3.5 Preferred to use an existing relationship for involvement in research.* The mothers preferred the psychologist who conducted the SFBT session to conduct the IPA interview as well. All felt that honesty was not an issue.

'I realize the importance of being totally honest. I wouldn't say something just to be nice because it was you sitting there.'

(Alison)

They were concerned that a third party's involvement would have misinterpreted and misrepresented them.

'I wouldn't want a market researcher . . . you've got the background, the authority.'

(Jenny)

There was a feeling of trust, understanding and valuing. Continuity prompted recall and increased privacy. One participant who volunteered to read drafts of the paper also wished to have a two-way relationship with the practitioner as described in this quotation.

'If it had been somebody else, first of all I would have felt that we were starting all over again from the beginning, secondly you have been able to remind me . . . somebody else with a different voice wouldn't have triggered the same memories in my head at all . . . being spied upon is too strong a word but at the moment I feel I'm being helpful to somebody who is doing research but also has a connection to me and my son . . . I had to see so many professionals . . . that the fewer I see and the more continuity I have the better.'

(Emma)

## **Discussion**

### *Validity of the analysis*

The study is a practitioner's interpretation of the experiences of a small group of clients. It was conducted under the close scrutiny of the clients, supervisor and peer groups. The validation exercises indicate that it meets the criteria for the integrity of qualitative research, i.e. it is credible, transferable and dependable (Elliot *et al.*, 1999; Stiles, 1993; Turpin *et al.*, 1997). Qualitative studies cannot provide the seeming 'objectivity' of research but can provide an in-depth perspective from those who were there. The methodology enables practitioners and clients to share experiences that may inform and

stimulate ideas for clinical practice and research (Ashworth, 2003; Robson, 2002). It is similar to that used by Messari and Hallam (2003) to gain insight into clients' experiences of therapy.

User involvement in the development and evaluation of therapy is still a relatively new venture. During the interview the mothers were asked about the design. They were adamant that it was their preferred method for involvement in research because a trusting, collaborative relationship had been established. They feared that an 'objective' researcher would misrepresent them. If practitioners are to genuinely collaborate with service users, such concerns need to be considered.

## **Discussion of the findings**

### *SFBT experienced as an amplifier of self-efficacy*

The findings suggest that there was some synchrony between SFBT and ways of thinking that the mothers found helpful. The theme 'making the best of it' seems to capture the essence of SFBT. The mothers were not specifically asked about their attitude to caring, yet 'making the best of it' recurred almost verbatim in all of the accounts in response to questions about the experience of SFBT. An alternative interpretation is that the mothers lived with this idea and it overrode memories of the previous SFBT session. However, there are striking similarities between elements of 'making the best of it' and the core assumptions of SFBT (Table 1). The interpretation was made that SFBT both encouraged the mothers to think in this way and resonated with a style of thinking that they found helpful. It was congruent with their personal philosophy and attempted solution to their situation. This was endorsed as SFBT components were adopted or referred to in sub-themes of 'making the best of it'.

Feelings of self-efficacy appeared to be amplified and developed for the mothers. Confidence in their ability to take control was apparent as they described the way they 'made the best of it'. The words they used often suggested pride, effort and endurance. Data from the Salamanca SFBT research group also suggested that a sense of self-efficacy develops or is reinforced in SFBT sessions. They noted that clients who commence consultations with a strong locus of control have better outcomes (Beyebach *et al.*, 1996, 2000). Allen (1999) suggests that mothers who have a strong locus of control are more likely to comply with behavioural interventions for their child with ID.

A belief in one's capacity to create change is believed to assist with coping and adaptation for families of a child with ID (Hastings and Taunt, 2002; Olsson and Hwang, 2002). Hastings and Brown (2002) demonstrated that self-efficacy mediates the effect of the child's behaviour on mothers' anxiety and depression, and moderates the impact of behaviour problems on fathers'.

Perceiving the child as a source of maternal fulfilment also appears to be a factor that helps families to adapt and cope (Hasting and Taunt, 2002), and attaching meaning to the caring role (Olsson and Hwang, 2002). This emerged in some mothers' accounts (e.g. Tina, who perceived that her son made her a 'better person'). Wheeler (2001) suggests that SFBT may loosen problem-oriented perceptions of the child that could damage attachment if they are not addressed.

### *The 'miracle question'*

The mothers forcefully expressed the view that the 'miracle question' was irrelevant or baffling for them, although not upsetting. Five stated that it was the least helpful aspect of the session. Their views endorse the practice of SFBT practitioners who use alternatives (e.g. enquiring about best hopes for therapy and visualizing success) (Letham, 2002; Neilson-Clayton and Brownlee, 2002; O'Hanlon, 2003; Stoddart *et al.*, 2001).

Prior to SFBT the mothers had already, often secretly, considered the miracle of their child being cured; the word *miracle* appeared to make them revisit or reconsider this. Possibly the question has a different impact at different stages of the life cycle or stage of acceptance. The 'miracle question', in which an external agent creates change, is similar to 'wishful thinking' that is described by Kim *et al.* (2003) as an emotion-focused coping strategy. A strategy associated with situations in which the parent had little control or a poorer relationship with the child appeared to amplify rather than diminish feelings of distress, burden and depression. In contrast, in Kim *et al.* (2003) good adaptation and a better relationship with the child were associated with the use of active problem-solving strategies, similar to those employed in 'making the best of it'.

There was unanimity between the seven mothers that the most helpful aspects of SFBT were visualizing the preferred future in detail and the scaling task. It seemed that the scaling exercise permitted them to hold on to hope by placing the miracle at 10. It seemed to put the covert hope into the open. Then through the scaling they focused

on how change occurred for their child and how more change could occur, usually due to the parents' own efforts. In this way it seemed to acknowledge and then loosen an allegiance to wishful thinking, where an external agent creates change, and to emphasize and encourage self-efficacy or an internal locus of control.

#### *SFBT as a process for eliciting parents' expertise in readiness for collaboration*

SFBT protocol suggests that practitioners take a non-expert position and elicit solutions from the client who is the expert on their own situation. However, these mothers valued suggestions highly and wanted more. This is consistent with parents' requests for information from services (e.g. Pain, 1999) and government guidance to collaborate (Department of Health, 2001a, 2001b). The idea of collaboration involves sharing expertise. It would be unethical to withhold an idea from the family by rigidly adhering to the idea of eliciting. The recommendation arising from these mothers' experiences is that the SFBT non-directive curious stance is valuable to elicit parents' expertise. Later it is likely to be useful in integrating what has been heard with the therapists' knowledge and skills in a way that builds upon and respects both parties' skills.

Consistent with this, Beyebach and Carranza (1997) and Beyebach *et al.* (1996, 2000) found that successful SFBT sessions were characterized by a long listening phase and a short, more therapist-dominated ending phase, with a message or inter-session task. Less successful sessions had a similar interaction style throughout. Sundman (1997) found that SFBT training resulted in increases in positive statements, greater focus on goals and more shared views between clients and social workers. Bowles *et al.* (2001) found improvements in nurses' willingness to communicate with troubled individuals, increased feelings of adequacy and decreased levels of stress.

#### *Recommendations and reflections*

Reflecting with the mothers about their initial SFBT session has left an impression that it is a useful first session tool for families supporting a child with severe ID. Significant change may or may not occur in first sessions but the strength of SFBT seems to be the way parents' expertise is elicited and valued which draws self-efficacy out. There seems to be synchrony between SFBT and philosophies that the

parents find helpful and is endorsed by research on coping and cognitions. The study has generated a hypothesis that SFBT could have a role in validating and supporting helpful coping strategies. Future studies of SFBT could use self-efficacy/locus of control and coping styles as outcome measures to test this.

The mothers were clear that the miracle question was not helpful, although excluding it is likely to mean that different themes emerge in sessions. Different phrases could be used to elicit a vision of a hypothetical future (e.g. 'What would a really good day look like?'). However, something quite striking did occur around the miracle question that felt uncomfortable but may be useful. Since completing the study it has been noticeable that many families ask about miracles or magic (e.g. at the outset of a session 'Have you got your magic wand today?'), or can seem stuck and disappointed that every suggestion the practitioner makes is not good enough. At these points discussing the findings of the study or asking the miracle question feels more natural and helpful. It may be that the miracle question has a place but it is a question of attunement; waiting for the parent to flag up the most helpful time and place rather than a therapeutic protocol. Another possibility is that it re-evokes the feelings of loss parents have been attempting to resolve and which may not have been voiced. It may be that as the therapeutic relationship develops these unresolved feelings may be safely and helpfully explored through the metaphor of the miracle question.

The study only looked at SFBT as a first session tool. In subsequent sessions parents often chose to pursue psychometric assessment and specific advice/behavioural interventions. However, there was a lasting anecdotal impression that the collaborative and valuing therapeutic alliance built in the first session endured and coloured future sessions. The overarching hypothesis generated from these interviews is that SFBT prepared mothers for other interventions as a therapeutic alliance that emphasized self-efficacy, and examined wishful thinking was negotiated. Evaluating first session SFBT as a means of developing a therapeutic alliance would be extremely interesting.

Hearing clients' in-depth views and experiences of sessions has been humbling and illuminating. These mothers welcomed this approach to developing and researching therapeutic methods. Their experiences suggest that first session SFBT, with adaptations, can be integrated usefully into work aimed at supporting carers and those they care for.

## References

- Allen, D. (1999) Mediator analysis: an overview of recent research on carers supporting people with intellectual disability and challenging behaviour. *Journal of Intellectual Disability Research*, **43**: 325–339.
- Ashworth, P. (2003) The origins of qualitative psychology. In J. A. Smith (ed.) *Qualitative Psychology. A Practical Guide to Research Methods*. London: Sage.
- Beyebach, M. (2000) *European Brief Therapy Association Outcome Study: Research Definition*. Retrieved 29 November 2002 from World Wide Web: [<http://www.ebta.nu/sfbt-researchdefinition.html>]
- Beyebach, M. and Carranza, V. E. (1997) Therapeutic interaction and dropout: measuring relational communication in solution-focused therapy. *Journal of Family Therapy*, **9**: 173–212.
- Beyebach, M., Rodriguez Morejon, A., Palenzuela, D. L. and Rodriguez-Arias, J. L. (1996) Research on the process of solution-focused therapy. In S. D. Miller, M. A. Hubble and B. L. Duncan (eds) *Handbook of Solution-focused Brief Therapy*. San Francisco, CA: Jossey Bass, pp. 299–334.
- Beyebach, M., Rodriguez Sanchez, M., Arribas de Miguel, J., Herero de Vega, M., Hernandez, C. and Rodriguez Morejon, A. (2000) Outcome of solution-focused therapy at a university family therapy centre. *Journal of Systemic Therapies*, **19**: 116–128.
- Bliss, E. V. (2002) *SFBT with Adults who Have Learning Disabilities*. European Brief Therapy Association Conference abstracts.
- Bowles, N., Mackintosh, C. and Torn, A. (2001) Nurses' communication skills: an evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing*, **36**: 347–354.
- Bruce, E. and Schultz, C. (2002) Non-finite loss and challenges to communication between parents and professionals. *British Journal of Special Education*, **29**: 9–13.
- Butler, W. R. and Powers, K. V. (1996) Solution-focused grief therapy. In S. D. Miller, M. A. Hubble and B. L. Duncan (eds) *Handbook of Solution-focused Brief Therapy*. San Francisco, CA: Jossey Bass, pp. 228–250.
- Cunningham, C. and Davis, H. (1985) *Working with Parents: Frameworks for Collaboration*. Milton Keynes: Open University Press.
- Department of Health (1999) *Caring about Carers: A National Strategy*. Retrieved 1 August 2002 from <http://www.doh.gov.uk/carers.htm>.
- Department of Health (2001a) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: HMSO.
- Department of Health (2001b) *Family Matters; Counting Families In*. London: HMSO.
- de Shazer, S. (1982) *Patterns of Brief Family Therapy: An Ecosystemic Approach*. New York: The Guilford Press.
- de Shazer, S. (1985) *Keys to Solution in Brief Therapy*. New York: Norton.
- de Shazer, S. (1988) *Clues: Investigating Solutions in Brief Therapy*. New York: Norton.
- de Shazer, S. (1997) Some thoughts on language use in therapy. *Contemporary Family Therapy: An International Journal*, **19**: 133–141.
- de Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W. C. and Weiner-Davis, M. (1986) Brief therapy: focused solution development. *Family Process*, **25**: 207–221.

- Elliot, R. and Shapiro, D. A. (1988) Brief structured recall: a more efficient method for studying significant therapy events. *British Journal of Medical Psychology*, **61**: 141–153.
- Elliot, R., Fischer, C. T. and Rennie, D. (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, **38**: 215–229.
- Fidell, B. (2000) Exploring the use of family therapy with adults with a learning disability. *Journal of Family Therapy*, **22**: 308–323.
- Frankish, P. and Terry, S. (2003) Modern therapeutic approaches in learning disability. *Tizard Learning Disability Review*, **8**: 3–10.
- Franklin, C., Biever, J., Moore, K., Clemons, D. and Scamardo, M. (2001) The effectiveness of solution-focused therapy with children in a school setting. *Research on Social Work Practice*, **11**: 411–434.
- George, E., Iveson, C. and Ratner, H. (2003) *Solution Focused Therapy Course Notes*. London: The Brief Therapy Practice.
- Gingerich, W. (2001) *Research* Retrieved 18 March 2003 from: [www.gingerich.net](http://www.gingerich.net).
- Gingerich, W. and Eisengart, S. (2000) Solution-focused brief therapy: a review of the outcome research. *Family Process*, **39**: 477–498.
- Grant, G. and Ramcharan, P. (2001) Views and experiences of people with intellectual disabilities and their families. (2) The family perspective. *Journal of Applied Research in Intellectual Disabilities*, **14**: 363–380.
- Grant, G., Nolan, M. and Keady, J. (2003) Supporting families over the life course: mapping temporality. *Journal of Intellectual Disability Research*, **47**: 342–351.
- Grant, G., Ramcharan, P., McGrath, M., Nolan, M. and Keady, J. (1998) Rewards and gratifications among family caregivers: towards a refined model of caring and coping. *Journal of Intellectual Disability Research*, **42**: 58–71.
- Hastings, R. and Brown, T. (2002) Behaviour problems of children with autism, parental self, and self-efficacy. *American Journal on Mental Retardation*, **107**: 222–232.
- Hastings, R. and Taunt, H. (2002) Positive perceptions in families of children with developmental disabilities. *American Journal on Mental Retardation*, **107**: 116–127.
- Hastings, R. P., Allen, R., McDermott, K. and Still, D. (2002) Factors related to positive perceptions in mothers of children with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, **15**: 269–275.
- Kim, H. W., Greenberg, J. S., Seltzer, M. M. and Kraus, M. W. (2003) The role of coping in maintaining the psychological well-being of mothers of adults with intellectual disability and mental illness. *Journal of Intellectual Disability Research*, **47**: 313–327.
- Knight, M. T., Wykes, T. and Hayward, P. (2003) ‘People don’t understand’: an investigation of stigma in schizophrenia using interpretative phenomenological analysis. *Journal of Mental Health*, **12**: 209–222.
- Knox, M., Parmenter, T. R., Atkinson, A. and Yazbeck, M. (2000) Family control: the views of families who have a child with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, **13**: 17–28.
- Lee, M. Y. (1997) A study of solution-focused brief family therapy: outcomes and issues. *The American Journal of Family Therapy*, **25**: 3–17.

- Letham, J. (2002) Brief solution focused therapy. *Child and Adolescent Mental Health*, **7**: 189–192.
- Llewelyn, S. P. (1988) Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, **27**: 223–237.
- Llewelyn, S. P., Elliot, R., Shapiro, D. A., Hardy, G. and Firth-Cozens, J. (1988) Client perceptions of significant events in prescriptive and exploratory periods of individual therapy. *British Journal of Clinical Psychology*, **27**: 105–114.
- Lloyd, H. and Dallos, R. (2006) Solution-focused brief therapy with families who have a child with severe intellectual disabilities: a description of the content of initial sessions and the processes. *Clinical Child Psychology and Psychiatry*, **11**: 367–387.
- McKeel, A. J. (1996) A clinician's guide to research on solution-focused brief therapy. In S. D. Miller, M. A. Hubble and B. L. Duncan (eds) *Handbook of Solution-focused Brief Therapy*. San Francisco, CA: Jossey Bass, pp. 251–272.
- Messari, S. and Hallam, R. (2003) CBT for psychosis: a qualitative analysis of clients' experiences. *British Journal of Clinical Psychology*, **42**: 171–188.
- Metcalfe, L., Thomas, F. N., Duncan, B. L., Miller, S. D. and Hubble, M. A. (1996) What works in solution-focused brief therapy: a qualitative analysis of client and therapist perceptions. In S. D. Miller, M. A. Hubble and B. L. Duncan (eds) *Handbook of Solution-focused Brief Therapy*. San Francisco, CA: Jossey Bass, pp. 335–350.
- Miller, G. and de Shazer, S. (2000) Emotions in solution-focused therapy: a re-examination. *Family Process*, **39**: 5–23.
- Miller, S. D., Hubble, M. A. and Duncan, B. L. (1996) *Handbook of Solution-focused Brief Therapy*. San Francisco, CA: Jossey Bass.
- Neilson-Clayton, H. and Brownlee, K. (2002) Solution-focused brief therapy with cancer patients and their families. *Journal of Psychosocial Oncology*, **20**: 1–13.
- O'Hanlon, W. H. (2003) *A Guide to Inclusive Therapy*. New York: Norton.
- O'Hanlon, W. H. and Weiner-Davis, M. (1989) *In Search of Solutions: A New Direction in Psychotherapy*. New York: Norton.
- Olsson, M. B. and Hwang, C. P. (2002) Sense of coherence in parents of children with different developmental disabilities. *Journal of Intellectual Disability Research*, **46**: 589–559.
- Osborn, M. and Smith, J. A. (1998) The personal experience of benign lower back pain: an interpretative phenomenological analysis. *British Journal of Health Psychology*, **3**: 65–83.
- Pain, H. (1999) Coping with a child with disabilities from the parents' perspective: the function of information. *Child: Care, Health and Development*, **25**: 299–312.
- Rhodes, J. (2000) Solution-focused consultation in a residential setting. *Clinical Psychology Forum*, **141**: 29–33.
- Rhodes, J. and Amjal, Y. (1995) *Solution Focused Thinking in Schools*. London: Brief Therapy Press.
- Robson, C. (2002) *Real World Research: A Resource for Social Scientists and Practitioner-researchers*. Oxford: Blackwell.
- Rolland, J. S. (1997) The meaning of disability and suffering: socio-political and ethical concerns. *Family Process*, **36**: 437–440.
- Saetersdal, B. (1997) Forbidden suffering: the Pollyanna syndrome of the disabled and their families. *Family Process*, **36**: 431–435.

- Sebba, J. (1989) Profound and multiple handicaps: monitoring clients and their parents. *Irish Journal of Psychology*, **9**: 286–308.
- Shearn, J. and Todd, S. (1997) Parental work: an account of the day to day activities of parents of adults with learning disabilities. *Journal of Intellectual Disability Research*, **41**: 285–301.
- Smith, I. C. (2004) Solution-focused brief therapy with people with learning disabilities: a case study. *British Journal of Learning Disabilities*, **32**: 1–4.
- Smith, J. A. (2003) *Qualitative Psychology. A Practical Guide to Research Methods*. London: Sage.
- Smith, J. A., Jarman, M. and Osborn, M. (1999) Doing interpretative phenomenological analysis. In M. Murray and K. Chamberlain (eds) *Qualitative Health Psychology*. London: Sage.
- Stiles, W. B. (1993) Quality control in qualitative research. *Clinical Psychology Review*, **13**: 593–618.
- Stoddart, K. P., McDonnell, J., Temple, V. and Mustata, A. (2001) Is brief better? A modified brief solution-focused therapy approach for adults with a developmental delay. *Journal of Systemic Therapies*, **20**: 24–40.
- Sundman, P. (1997) Solution-focused ideas in social work. *Journal of Family Therapy*, **19**: 159–172.
- Thompson, R. and Littrell, J. M. (1998) Brief counselling for students with learning disabilities. *The School Counsellor*, **2**: 60–67.
- Tollinton, G. (1999) Helping and hindering recovery from stroke. *Clinical Psychology Forum*, **131**: 21–23.
- Tollinton, G. and Tollinton, H. (1996) Some personal experiences of solution-focused brief therapy. *European Brief Therapy Association Newsletter*, 1.
- Turpin, G., Barely, V., Beail, N., Scaife, J., Slade, P. and Smith, J. A. (1997) Standards for research projects and these involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum*, **108**: 3–7.
- Vetere, A. (1993) Using family therapy in services for people with learning disabilities. In J. Carpenter and A. Treacher (eds) *Using Family Therapy in the Nineties*. Oxford: Blackwell.
- Wheeler, J. (2001) A helping hand: solution-focused brief therapy and child and adolescent mental health. *Clinical Child Psychology and Psychiatry*, **6**: 293–306.
- Witts, P. and Gibson, K. B. (1997) Satisfaction with an adult learning disability community support team. *Journal of Applied Research in Intellectual Disabilities*, **10**: 41–47.