



Utilizing Solution-Focused Brief Therapy with Families Living with Autism Spectrum Disorder

Sara Smock Jordan & Brie Turns

To cite this article: Sara Smock Jordan & Brie Turns (2016) Utilizing Solution-Focused Brief Therapy with Families Living with Autism Spectrum Disorder, *Journal of Family Psychotherapy*, 27:3, 155-170, DOI: [10.1080/08975353.2016.1199766](https://doi.org/10.1080/08975353.2016.1199766)

To link to this article: <http://dx.doi.org/10.1080/08975353.2016.1199766>



Published online: 02 Aug 2016.



Submit your article to this journal [↗](#)



Article views: 712



View related articles [↗](#)



View Crossmark data [↗](#)

Utilizing Solution-Focused Brief Therapy with Families Living with Autism Spectrum Disorder

Sara Smock Jordan and Brie Turns

Community, Family, and Addiction Sciences, Texas Tech University, Lubbock, Texas, USA

ABSTRACT

Autism Spectrum Disorder is a growing phenomenon impacting the lives of children and their families. Although resources in the medical community exist for individuals dealing with Autism Spectrum Disorder, systemic psychotherapy resources for families are lacking. This article discusses the challenges that families coping with Autism Spectrum Disorder possess as well as their strengths. Solution-focused brief therapy is offered as a resource-based systemic approach to helping Autism Spectrum Disorder families. This article provides an overview of solution-focused brief therapy approach, a rationale for using it with Autism Spectrum Disorder families, and an example transcript of applying the model.

KEYWORDS

ASD; autism;
solution-focused brief
therapy

Introduction

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterized by social and communication deficits, as well as repetitive behaviors (American Psychiatric Association, 2013) affecting both individuals and their family unit (Falk, Norris, & Quinn, 2014). Currently, the prevalence rate of ASD is approximately 1 in 68 children (Autism and Developmental Disabilities Monitoring (ADDM), 2014), an increase from 1 in 88 (ADDM, 2012). With a growing rate of ASD diagnosing, and the systemic impact on an affected families, the need for systemically trained therapists is greater than ever for this population. The goal of this article is to discuss the challenges that ASD presents for families and provide a resource-based clinical model that addresses these unique needs. A case example using solution-focused brief therapy (SFBT) is offered as a systemic intervention for working with ASD.

Families living with ASD

Autism is considered to be the most severe childhood behavioral disorder (Newsom & Hovanitz, 2006). Although more children are receiving an ASD diagnosis than cancer and Downs Syndrome, society remains uninformed about

autism and its effects on children and their families (Muhle, Trentacoste, & Rapin, 2004). Because autism does not have a “cure” it is important to educate families, as well as the systems where these families live, about the severity of ASD’s symptoms, the lack of social norms displayed by an ASD individual, and the coping needed for families to deal with its stressors (Bristol, 1984; Lantos, 2007). This section will highlight the unique challenges to both parents and siblings in these families.

Parental effects

Social, behavioral, and communication deficits are the cornerstones of ASD leading to parental embarrassment and the need to defend their parenting skills (Ling, Mak, & Cheng, 2010). Social interactions with others become minimized, leaving parents feeling isolated from others due to the assumption that their extended family and friends will not understand the demands of caregiving that they endure (Woodgate, Ateah, & Secco, 2008). Parents are often labeled as a “bad parent” by extended family, church members, and others living in their community (Neely-Barnes, Hall, Roberts, & Graff, 2011). Due to the lack of physical indicators displayed in an individual with ASD, it is often difficult for others to “see” that a child has special needs and attributes the child’s behavior to a lack of parenting skills (Neely-Barnes et al., 2011).

While it is somewhat understandable that the general population lacks information about ASD, surprisingly professional environments also lack awareness of the unique challenges that ASD families face. Parents have reported feelings of separation and lack of support in health care settings, educational facilities, and other helping professionals (Woodgate et al., 2008). These experiences have been attributed to parents’ diminished sense of hope and feeling like an outsider in their child’s treatment.

Parents of ASD children have reported higher levels of parenting stress than parents raising a child with Down Syndrome, fragile X syndrome, cerebral palsy, and intellectual disability (e.g., Abbeduto et al., 2004; Blacher & McIntyre, 2006; Dabrowska & Pisula, 2010; Khanna et al., 2011). These stressors can lead to increased rates of depression (Benson, 2006; Gray, 2002), emotional distress (Little, 2002), isolation (Woodgate et al., 2008), and burnout (Sivberg, 2002). The impact of stress on these families has been linked with a lack of family cohesion and adaptability (Higgins, Bailey, & Pearce, 2005), as well as decreased marital satisfaction and an approximate increase in divorce by 10% (Hartley et al., 2010).

In addition to the emotional, social, and relational strains of ASD, financial issues also exist. (Glazzard & Overall, 2012). Not only are services for ASD costly, but the daily demands of care often result in one parent quitting their job to care for the child full-time (Jarbink, McCrone, Fombonne, Zanden, & Knapp, 2007). As bills increase and the household income often decreases, financial strains can be a major barrier for families. Overall, few disabilities

have shown to be more demanding on parents than having a child with an ASD diagnosis (Seltzer, Krauss, Orsmond, & Vestal, 2001).

Sibling experiences

Living with an ASD family member has also been shown to impact the non-diagnosed sibling. Bagenholm and Gilberg (1991) and Kaminsky and Dewey (2001) discussed that due to the social and cognitive limitations of the diagnosis, typically developing siblings have a difficult time forming satisfying relationships. More specifically, research shows that the non-ASD sibling possesses more negative views about their ASD sibling when compared to sibling pairs containing a child with mental retardation and a typical development child (Bagenholm & Gillberg, 1991). Children with an ASD sibling have also expressed only being able to talk with someone outside of the home about their sibling, feelings of loneliness and a desire to stay at home, and feeling concerned about their sibling's future (Bagenholm & Gillberg, 1991). These results could be linked to the non-diagnosed sibling's lack of knowledge regarding the diagnosis. Glasberg (2000) found that one out of five siblings stated that they had never heard the diagnostic term and discovered that parents overestimated their child's understanding of the disorder. Although it is unclear why there is a lack of communication among these subsystems, parents have reported feeling guilty for spending more time with their diagnosed child than their typical developing child (Glazzard & Overall, 2012). The lack of time spent with the undiagnosed child could contribute to the sibling's lack of information.

Familial strengths

Despite these negative experiences and aspects, families have reported an overall positive experience living with ASD and believed their families became closer (Bayat, 2007). Some parents reported that the diagnosis made their other children more empathic and compassionate (Neely-Barnes et al., 2011). Others reframed their family as being "extraordinary" rather than "weird" (Neely-Barnes et al., 2011, p. 218). Unfortunately, how families living with ASD manage and cope with the demands of the diagnosed child is likely to be impacted by the messages they receive from others outside of the home (Woodgate et al., 2008), including but not limited to extended family members, their community, media, and society, as a whole.

Systemic intervention for ASD families

Literature in the medical field has brought to light the importance of the entire family seeking treatment due to the complexities of an autism diagnosis. Specifically, nursing has stated that family therapy should

accompany the individual services that are provided to the child (Hall, 2012). Pediatrics has discovered that the quality services provided to parents of children with disabilities is directly related to parent optimism (Bailey, Nelson, Hebbeler, & Spiker, 2007).

Family therapists are ideal psychotherapists to work with ASD families. Neely, Amatea, Echevarria-Doan, and Tannen (2012) were some of the first authors that discussed contributions marriage and family therapists (MFTs) can make on families living with ASD (e.g., facilitating family grieving, serving as a coach, exploring various emotions). Currently, there is a lack of published articles educating MFTs on working with ASD families (Bradford, 2010; Neely et al., 2012) and existing literature only focuses on strengthening the parental unit (Brockman, Hussain, Sanchez, & Turns, 2016; Ramisch, 2012; Ramisch, Onaga, & Oh, 2014; Ramisch, Timm, Hock, & Topor, 2013; Solomon & Chung, 2012). Due to the increasing demand of systemic professionals needed to work with this population, a clinical model for MFTs is greatly needed. This article proposes a SFBT model for working with ASD families in order to: (1) provide MFTs with resources for working with a growing number of families facing the complexities of ASD and (2) decrease the negative experiences families are already enduring from society. We will give an overview of the SFBT model, provide a family case study, and justification for why SFBT is a good model for this population.

Overview of SFBT

SFBT is a systemic approach that focuses on co-creating a client's preferred future. Listening for exceptions to the client's problems, goal setting, and tracking client's progress are components of SFBT. Through the process of listen, select, and build (De Jong & Berg, 2013), a therapist and client co-construct solutions, preferred ways of being in the near future.

Doing SFBT

The *process* of doing SFBT contains three parts according to SFBTA's manual (Bavelas et al., 2013). In SFBT, it is important to focus on what is occurring between the therapist and client (their interaction) in dialogue. Some models of therapy focus on internal processes of therapists and/or clients. The heart of the SFBT approach lies in the importance of language, the interactional effects that are occurring in dialogue. Next, focusing on what is observable, what is really happening between the client and therapist in their dialogue, is another important piece of the SFBT process. Observable actions in dialogue include gestures, gaze, tone of voice, context of the conversation, topic choice, formulations, and questions. Recently, a micro-model for observing co-construction in face-to-face dialogue has been discovered (see Bavelas, de

Jong, Jordan, & Korman, 2014) that can be helpful in understanding the process of SFBT. Finally, the process of doing SFBT developed from communication research (Bavelas, et al., 2013).

Listen, select, and build

So what does the process of doing solution focused brief therapy look like? de Jong and Berg (2013) coined the phrase *listen, select, and build* which describes what is actually going on in SFBT dialogue. In SFBT, the therapist is constantly *listening* for the client's words and phrases that give some small indication of the client's resources, what the client's preferred future (solution), and/or related successes (e.g., exceptions to the problem). Within a micro-moment after hearing an example of an exception, the therapist *selects* this piece of client content and *builds* a question or uses a formulation (e.g., a paraphrase or summary of the client's content) to move the conversation toward a clearer depiction of the client's preferred future. The process of *listen, select, and build* occurs throughout the entire session, over and over again, to co-create the client's description of where they would like to be in the near future.

Key interventions and protocols

While every therapeutic session uses the process of *listen, select, and build*, what the therapist listens for, selects, and builds is different in SFBT. SFBT therapists listen for (1) what matters to the client; (2) what the client wants; (3) prior client successes/exceptions to their problem; and (4) the client's own resources (Bavelas et al., 2013). Then, SFBT therapists *select* details of the client's language to either *build* formulations or implement key SFBT interventions questions (e.g., miracle, scaling, etc.). Over the years, more of an emphasis has been placed on the process of co-construction (see de Jong, Bavelas, & Korman, 2013); however, knowing the classic SFBT questions and interventions are still very important.

Goal-formulation (including the miracle question), scaling, relational, coping, exception, and questions are types of key SFBT questions that occur throughout the session. Taking a break, giving compliments, and providing homework are techniques that occur at the end of SFBT sessions. A typical first session uses the following key interventions while maintaining the process of *listen, select, and build* (see Table 1, adapted from de Jong & Berg, 2013).

It is suggested to use the following format for later SFBT sessions (see Table 2; de Jong & Berg, 2013).

Another important type of question that can be used through a session are relational questions. Relational questions might be phrased as "So what would be the first thing that your husband notices after the miracle?" or "What difference would it make to your son if you were more patient during his outbursts?" These are often helpful to ask when family members feel stuck answering the therapist's questions.

Table 1. Key interventions for first SFBT sessions.

Key interventions	Example questions/Description of intervention
Having the client identify their problem	-So, how can I be helpful to you today?
Asking goal-formulating questions	-What do you want to see changed as a result of coming here today? -Asking the miracle question (see Berg & Dolan, 2001)
Highlighting exceptions	-Are there times when the problem is not as bad?
Asking scaling questions	-On a scale from 1 to 10, how well are you coping with your daughter's outbursts?
-Coping	-On a scale from 1 to 10, how confident are you that thing will improve at home?
-Confidence	
Take a break and develop compliments for the client	-The therapist can leave the room or take a break in their chair, gathering their thoughts, and developing compliments
Compliments	-Compliments are based on what the client(s) reported that they (1) like about themselves, (2) are proud of, (3) things they are doing well
Homework	-Homework should come from what the client has mentioned that would be helpful/useful.

Table 2. Follow-up SFBT session format.

Key interventions	Example questions/Description of intervention
What's better	-So what has been better since the last time we met?
Start again	What's going on that's better?
*Note: If nothing better is reported	-So how did you do that? -What difference did you notice since you have been taking more time for yourself? -So what else is better? -How are you keeping things from getting worse?
Doing more	-So what will it take to keep this going?
Scaling progress	-On a scale of 1–10, where 10 is [their goal], where are you this week?
Current	-When you move up one point on the scale of [define goal], what will that look like?
Future	
Take a break and develop compliments for the client	-The therapist can leave the room or take a break in their chair, gathering their thoughts, and developing compliments
Compliments	-Compliments are based on what the client(s) reported that they (1) like about themselves, (2) are proud of, (3) things they are doing well
Homework	-Homework should come from what the client has mentioned that would be helpful/useful.

Rationale for using SFBT with families living with ASD

So why use SFBT with families living with ASD? Families with an ASD member face many challenges. Financial and time constraints, the need to be the expert of their child's life, and the need for possessing coping strategies are all important pieces to consider when working with ASD families. The following section will describe the advantages of using SFBT with ASD individuals and their family members.

Financial and time constraints

Families living with an ASD member undergo many financial constraints. Medical appointments, intensive applied behavior analysis (ABA) treatment, nutrition/dietician appointments, speech, occupational, and physical therapy all lead to a monetary strain on the family system (Glazzard & Overall, 2012). It is projected that the lifetime cost of raising one child with ASD in the United States is approximately \$3.2 million (Ganz, 2007).

In addition to the immense financial pressures on these families, time constraints also play a major role. Juggling multiple appointments for ASD children often forces one parent to quit their job, another financial factor, and assume full-time management of making necessary appointments (Myers, Mackintosh, & Goin-Kochel, 2009). Balancing work and caring for their ASD child often times becomes unmanageable for both parents to work outside of the home.

While therapists vary in the amount they charge their clients, regardless of therapist's fee, SFBT becomes an optimal solution for ASD families for several reasons. First, SFBT is a brief model of therapy. *Brief* therapy is often misunderstood to mean a restricted number of sessions. While brief therapy does tend to be shorter than non-brief approaches, the goal of brief therapies is to address the presented needs of the clients. Given that families with ASD members face financial and time constraints, SFBT is an optimal fit because it focuses on the specific needs and goals that clients bring to session. Second, SFBT is a good fit for ASD families trying to manage their financial and time obligations because therapists meet with clients only as often as is helpful for clients. At the end of any given session, a SFBT therapist asks their clients a variation of "so when would it be helpful or useful to meet again." This allows clients to only schedule appointments as often as it fits into their budget and/or schedule.

Experts of their child's life

Literature on ASD families shows that parents input and commitment in their child's treatment and lives is crucial (Woodgate et al., 2008) and parents overall involvement in their child's life increases parental self-efficacy (Hastings & Brown, 2002). Professionals working with ASD families often isolate parents from their child's treatment. For example, Woodgate et al. (2008) stated that parents often report feeling like an outsider by the system (i.e., agencies, educational setting, etc.) in their child's treatment. In addition, parents are often feel pressured to defend their parenting techniques or become embarrassed about their child's behavior (Ling et al., 2010).

One hallmark of SFBT is that the clients are the experts of their own lives (de Shazer, 1985). By using a SFBT approach with both parents and children,

the family becomes an expert on what will work best for them. Empowering clients to work on goals that fit best for their circumstances is a refreshing change for families living with ASD.

Coping

Coping is another important factor to consider when working with ASD families. Parents report that managing the needs of their child requires multiple coping mechanisms (Hall, 2012). Positive reframing is one type of coping strategy that can be useful to ASD families (Hastings et al., 2005; Pozo, Sarria, & Brioso, 2011). By offering an alternative behavior or idea to a child with ASD, both the child and the parent can lessen the occurrence of negative circumstances.

Coping is a foundational aspect of the SFBT approach (see Table 1). Asking families how they are able to cope with life challenges should occur in any session when clients are stating that things have been difficult or hard. By asking clients coping questions, a SFBT therapist is: (1) acknowledging the problem without engaging in problem talk, (2) assuming that the clients are coping to some degree with their challenges, and (3) providing the ability to measure improvement from session to session. SFBT recognizes that individuals and families with any type of disability, especially managing ASD symptoms, are able to successfully cope with their circumstances to some degree (Froerer & Pagan-Romney, 2014).

SFBT with an ASD family

Pre-family session recommendations

Before beginning treatment with a family living with ASD, Turns and Springer (2015) provide the following recommendations for therapists to implement, which fit well with the SFBT model. When speaking to the parent who initiates therapy, they recommend that you first see the parent (or both parents together if possible) without the ASD child. Visiting a new facility where additional paperwork may be needed upon arrival may provoke tantrums or other unwanted behavior from the ASD child. During the intake session, discuss each parent's view of the family subsystems and the reason for seeking treatment. Froerer and Pagan-Romney (2014) recommend not assuming that the clients are seeking therapy primarily because one of their family members possesses a disability. Once the parent's best hopes are determined, the therapist will ask if it is helpful for the ASD child, and any other siblings, to attend future sessions. If it is helpful to have the ASD child in session, the therapist can ask parents to bring some of the child's preferred items or activities

(Turns & Springer, 2015). This will not only help the child to feel more comfortable in the room, but may aid in the joining process. Prior to the family session, therapists should assess the therapy room for potential sensory issues, including but not limited to, lighting, smells, sounds, and textures. Finally, it is recommend that therapists become more comfortable with the individual child's potential behaviors (e.g., self-stimulating behaviors, etc.) that may occur in the room (Turns & Springer, 2015).

Case example: Spider-Man of the outside

The following is a SFBT family therapy case example. Before this family session, the therapist met with Jane (42), Leroy's (8) mother, following the above recommendations. It was decided by Jane in the initial session that it would be most helpful if Leroy attended their family session. Jane stated that she would like for Justin and Harper (14), Leroy's older sister, to attend but only Harper could attend because Justin's schedule currently doesn't fit the therapist's availability. Jane's best hopes for therapy were to better cope with Leroy's fascination with water. Jane stated that Leroy was diagnosed with ASD last year by his pediatrician. Jane described herself as Leroy's primary caregiver because Justin (48), Leroy's father, works two jobs in order to cover his son's rigorous treatments (physical and speech therapy and applied behavior analysis). Jane reported Leroy has been wandering off to find bodies of water (pools, lakes, fountains, etc.). This behavior has caused concern because Leroy cannot swim, does not understand that he cannot swim, and will bolt if his parents do not have a firm grasp on him. The first portion of the session is transcribed below:

- (1) Therapist: So, how can I be helpful to all of you today?
- (2) Jane: Well, we are struggling with Leroy's urge to wander toward water.
- (3) Therapist: Oh, so Leroy likes water.
- (4) Leroy: [nods.]
- (5) Harper: yeah, he likes water too much
- (6) Therapist: Leroy, what do you like about water?
- (7) Leroy: [shrugs] it looks pretty and shiny
- (8) Therapist: Yes [nods] water is very pretty and shiny. I have a little pond [tupperware container filled with water] in my office over here. Would you like to play with it? Harper, you can come play too if you want.
- (9) Leroy: Yay!
- (10) Therapist: [Leads Leroy and Harper to the little pond. Jane hands Leroy and Harper the bath toys that she has brought from home, per the therapist's recommendation, for them to play with in the water].

So, it sounds like talking about Leroy's fascination with water would be useful during our time today.

- (11) Jane: Yes.
- (12) Therapist: So, what specifically would we talk about today regarding Leroy's fascination with water that would let you know this conversation has been useful?
- (13) Jane: Well, I just don't know how to keep him from getting into dangerous situations around water. It is so hard to keep him out of water.
- (14) Leroy: [rocking in his chair]
- (15) Therapist: So figuring out how to keep Leroy safe around water would be helpful?
- (16) Jane: Yes.
- (17) Therapist: Hmm. So how have you managed to keep Leroy safe thus far?
- (18) Jane: Well, I keep a real close eye on him [therapist nods] and try to keep him contained in the house unless my husband Justin is home. We only go on walks outside when Justin is there to help chase him if he takes off around water. This is ok, but I think it is really good for Leroy to be outside more...I just can't manage him on my own. Harper has been helping me with Leroy but Leroy will often throw tantrums when Harper tries to help.
- (19) Harper: Yeah, I try to help mom but sometimes Leroy is too fast for me.
- (20) Leroy: [Blurts out] I like water!
- (21) Therapist: Yes, Leroy it certainly sounds like you do! Do you like water too Harper?
- (22) Harper: Oh, yes.
- (23) Therapist: Your mom just told me how she keeps you safe around water, what do you do to stay safe around water?
- (24) Leroy: [pause] Umm. I dunno.
- (25) Therapist: Yeah, that's a hard question. [pause]
- (26) Leroy: I try to stay around the corners.
- (27) Therapist: You stay around the corners
- (28) Jane: He means the edge of the water
- (29) Harper: Yeah, he can't swim like me so he only stays in the shallow part.
- (30) Leroy: Yeah, I just like to get in the water to here [gestures using his hands to show that the water comes up to his knees]
- (31) Therapist: Oh, so you only like the water up to here [mimics Leroy's gesture]
- (32) Leroy: [nods]
- (33) Therapist: So it sounds like everyone in the family tries in different ways to keep Leroy safe around water but mom, it seems like you can

- imagine things being better still. Being able to have Leroy outside more when it is just the two of you while keeping him safe.
- (34) Jane: Exactly. I guess Harper and I wouldn't worry so much when we are outside that Leroy is going to drown.
- (35) Therapist: So you would also be feeling less worried too? So, if you weren't as worried about Leroy's safety around water, what would you be doing instead?
- (36) Jane: [Smiles and chuckles] Well, I guess I would relax and enjoy being outside more. Right now I am just so anxious when I'm outside with him. I used to love being outside with Leroy but lately I am just so worried that he'll drown that we hardly go outside together.
- (37) Therapist: Hmm. So, there was a time when you used to be more relaxed outside with Leroy. What was different then?
- (38) Jane: Well, he hadn't figured out how much he liked water back then. It was never really a problem until 1 day when we went for a walk he got closer and closer to the lake at the park and then jumped into the water so quickly that it scared me to death. Of course, he has never gone out too far in the water but still, when you have a child on the spectrum you just never know when they are going to put themselves in a dangerous situation.
- (39) Therapist: Of course. That sounds very frightening. Have there been days since that scary incident that you have been able to relax and enjoy the outdoors with Leroy?
- (40) Jane: Well, if we are planning to go swimming and he is wearing his life jacket I feel more comfortable. Leroy and Harper have matching superhero life jackets so Harper encourages him to wear his to go swimming.
- (41) Therapist: Oh, so when Harper and Leroy wear their life jackets you feel more relaxed. Sure, that makes sense. So, Leroy and Harper tell me more about your superhero lifejackets.
- (42) Leroy: Yes! It is so cool! I'm Spider-Man when I wear it.
- (43) Therapist: Oh, you must really like Spider-Man.
- (44) Leroy: [jumps up and down] Spider-Man, Spider-Man, Spider-Man
- (45) Jane: [tries to settle Leroy down a bit and redirect him to play with the toys] Yes, he's a big fan.
- (46) Therapist: And Harper, tell me about yours
- (47) Harper: Mine is wonder woman. Even though I can swim my mom still wants me to wear my jacket when we go swimming.
- (48) Therapist: So Leroy, what if you could wear your Spider-Man jacket every time you, Harper, and your mom went outside to play.
- (49) Leroy: Please mommy. Can I be *Spider-Man of the outside*?
- (50) Jane: [smiles] I don't know why I haven't thought of that before. Yes, Leroy. Would you be Spider-Man when we play together outside?

- (51) Therapist: So [picks up a balloon that hasn't been inflated] if this balloon represents how much you want to be *Spider-Man of the outside* when you and mommy play outdoors, how full would it be? The fuller the balloon is the more you want to be *Spider-Man of the outside*.
- (52) Leroy: [very excited he gestures for a huge balloon]
- (53) Therapist: So like this [blows the balloon up as much as possible without popping it]
- (54) Leroy: Yes!!
- (55) Therapist: And mom, are you as confident as Leroy that he will wear his life jacket when you play together outside. Would you keep all of this air in this balloon to measure your confidence in Leroy?
- (56) Jane: Absolutely.
- (57) Therapist: What about you Harper? How confident are you that Leroy can wear his jacket? Can you blow up the balloon to show us?
- (58) Harper: Sure [she blows up the balloon as big as Leroy did].

Illustrating the process of listen, select, and build

The following dialogue with Jane, Harper, and Leroy illustrates how a SFBT therapist has the clients identify their problems, asks goal-formulating questions, highlights exceptions, and asks scaling questions. Again, the focus is not on doing interventions but on the process of listen, select, and build. Let's go through a few sequences of exchanges to illustrate the listen, select, and build process in this dialogue.

First, the therapist begins by asking a very typical SFBT opening question "So, how can I be helpful to both of you today?" Jane's response of "Well, we are struggling with Leroy's urge to wander toward water." allows the client to identify their problem, which follows the SFBT format. The therapist now has a choice about how they will respond to the first piece of information that is received in their conversation. As Jane is describing her problem, the therapist listens for and selects from the pieces of her utterance what would lead to a solution building conversation. In utterance #3, the therapist only selects the words "Leroy" and "water" from Jane's statement and adds "Oh, so" and "likes." The therapist could have chosen to focus on Leroy's struggle or his urge to wander but instead, the therapist rephrased Jane's problem as Leroy's fascination with water (Oh so Leroy *likes* water). For a beginning SFBT therapist this may seem like a small, insignificant choice in word usage. It is a very detailed, deliberate, choice in language but it is hardly trivial.

A few moments later, Jane restates her problem of keeping Leroy from "getting into dangerous situations around water." In a continued attempt to formulate a workable goal for the clients, the therapist selects "Leroy" and "around water" from utterance #10 and builds on the client's words by asking

“So figuring out how to keep Leroy safe around water would be helpful?” It is easy for therapists to get sucked-into a client’s problem-focused language early in a session. By carefully listening, selecting, and building on the client’s language to implement the key interventions of SFBT, solutions in problem-saturated families can be generated, especially families with an ASD member.

As you can see from the case example, the process of listen, select, and build fits hand-in-hand with the SFBT techniques. This process continues throughout an entire SFBT session, including taking and break, developing compliments, and giving homework.

Discussion

The purpose of this article has been to provide a useful model of therapy for working with ASD families. We have provided societal influences and common stressors of ASD families, an overview of the SFBT model, a rationale for using SFBT with ASD families, suggestions for meeting with parents prior to a family session, and a sample family session with details about the process of using the model. Since the field of MFT lacks systemic literature on this topic, our article serves as an initial introduction to working with these families.

Some modifications to the proposed SFBT model for ASD families may be necessary. Since most families with an ASD member are familiar with problem solving methods that behavioral modification professionals (i.e., behavioral analysts) use, introducing a solution-focused approach may be a paradigm shift. Explaining at the beginning of therapy that family members are the experts of their own lives may aid in the family’s understanding of solution-focused conversations. In some cases, an ASD child may be non-verbal. In these situations, it may be more useful to use SFBT play therapy (see Berg & Steiner, 2003) in family sessions. The use of puppets, toys, etc., may be appropriate when including a non-verbal ASD child in session.

Although ASD has been studied in various disciplines, efficacy and effectiveness research on working with ASD families is non-existent. Current research using systemic interventions with an ASD family is limited to enhancing the parental unit and lacks an integrative approach when working with the diagnosed child and his/her siblings. Future research on ASD family therapy using a SFBT model should include randomized controlled trials as well as process clinical research. Given the recent recognition of SFBT as an evidence-based approach (Franklin, Trepper, Gingerich, & McCollum, 2011) testing the efficacy, effectiveness, and process of using SFBT with ASD families should be widely supported in the MFT field.

References

- Abbeduto, L., Seltzer, M., Shattuck, P., Krauss, M., Orsmond, G., & Murphy, M. (2004). Psychological wellbeing and coping in mothers of youths with autism, down syndrome or fragile X syndrome. *American Journal on Mental Retardation*, *109*, 237–254. doi:10.1352/0895-8017(2004)109<237:PWACIM>2.0.CO;2
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Autism and Developmental Disabilities Monitoring Network Surveillance Year 2008 Principle Investigators. (2012). Prevalence of autism spectrum disorders- autism and developmental disabilities monitoring network, 14 sites, United States, 2010. *MMWR Surveillance Summary*, *61*(SS03), 1–19.
- Autism and Developmental Disabilities Monitoring Network Surveillance Year 2010 Principle Investigators. (2014). Prevalence of autism spectrum disorders among children aged 8 years- autism and developmental disabilities monitoring network, 11 sites, United States, 2010. *MMWR Surveillance Summary*, *63*(2), 1–21.
- Bagenholm, A., & Gillberg, C. (1991). Psychosocial effects on siblings of children with autism and mental retardation: A population based study. *Journal of Mental Deficiency Research*, *35*, 291–307.
- Bailey, D., Nelson, L., Hebbeler, K., & Spiker, D. (2007). Modeling the impact of formal and informal supports for young children with disabilities and their families. *Pediatrics*, *120*, e992–1001. doi:10.1542/peds.2006-2775
- Bavelas, J., de Jong, P., Franklin, C., Froerer, A., Gingerich, W., Kim, J., ... Trepper, T. S. (2013). Solution focused therapy treatment manual for working with individuals 2nd version. *Solution Focused Brief Therapy Association*, 1–42.
- Bavelas, J. B., de Jong, P., Jordan, S. S., & Korman, H. (2014). The theoretical and research basis of co-constructing meaning in dialogue. *Journal of Solution-Focused Brief Therapy*, *1*, 1–24.
- Bayat, M. (2007). Evidence of resilience in families of children with autism. *Journal of Intellectual Disability Research*, *51*, 702–714. doi:10.1111/jir.2007.51.issue-9
- Benson, P. (2006). The impact of child symptom severity on depressed mood among parents of children with ASD: The mediating role of stress proliferation. *Journal of Autism and Developmental Disorders*, *36*, 685–695. doi:10.1007/s10803-006-0112-3
- Berg, I., & Steiner, T. (2003). *Children's solution work*. New York, NY: Norton.
- Berg, I. K., & Dolan, Y. (2001). *Tales of solutions: A collection of hope-inspiring stories*. New York, NY: Norton.
- Blacher, J., & McIntyre, L. (2006). Syndrome specificity and behavioural disorders in young adults with intellectual disability: Cultural differences in family impact. *Journal of Intellectual Disability Research*, *50*, 184–198. doi:10.1111/j.1365-2788.2005.00768.x
- Bradford, K. (2010). Brief education about Autism spectrum disorders for family therapists. *Journal of Marital & Family Therapy*, *38*(2), 305–316.
- Bristol, M. (1984). Family resources and successful adaption to autistic children. In E. Schopler & G. Mesibov (Eds.), *The effects of autism on the family* (pp. 289–310). New York, NY: Plenum Press.
- Brockman, M., Hussain, K., Sanchez, B., & Turns, B. (2016). Managing child behavior problems in children with Autism spectrum disorders: Utilizing structural and solution focused therapy with primary caregivers. *American Journal of Family Therapy*, *44*(1), 1–10.
- Dabrowska, A., & Pisula, E. (2010). Parenting stress and coping styles in mothers and fathers of pre-school children with autism and down syndrome. *Journal of Intellectual and Disability Research*, *54*, 266–280. doi:10.1111/j.1365-2788.2010.01258.x

- de Jong, P., Bavelas, J., & Korman, H. (2013). An introduction to using microanalysis to observe co-construction in psychotherapy. *Journal of Systemic Therapies*, 32, 17–30. doi:10.1521/jsyt.2013.32.3.17
- de Jong, P., & Berg, I. K. (2013). *Interviewing for solutions* (4th ed.). Belmont, CA: Brooks/Cole, Cengage Learning.
- de Shazer, S. (1985). *Keys to solution in brief therapy*. New York, NY: W.W. Norton.
- Falk, N., Norris, K., & Quinn, M. (2014). The factors predicting stress, anxiety and depression in the parents of children with autism. *Journal of Autism and Developmental Disorders*, 44, 3185–3203. doi:10.1007/s10803-014-2189-4
- Franklin, C., Trepper, T., Gingerich, W., & McCollum, E. (Eds.). (2011). *Solution-focused brief therapy: A handbook of evidence-based practice*. New York, NY: Oxford University Press.
- Froerer, A., & Pagan-Romney, E. (2014). Solution-focused approach with clients with disabilities. In J. Kim (Ed.), *Solution-focused brief therapy: A multicultural approach* (pp. 166–179). Thousand Oaks, CA: Sage.
- Ganz, M. (2007). The lifetime distribution of the incremental societal costs of autism. *Archives of Pediatrics & Adolescent Medicine*, 161(4), 343–349. doi:10.1001/archpedi.161.4.343
- Glasberg, B. (2000). The development of sibling's understanding of autism. *Journal of Autism and Developmental Disorders*, 30, 143–156. doi:10.1023/A:1005411722958
- Glazzard, J., & Overall, K. (2012). Living with autistic spectrum disorder: Parental experiences of raising a child with autistic spectrum disorder (ASD). *Support for Learning*, 27(1), 37–45. doi:10.1111/sufl.2012.27.issue-1
- Gray, D. (2002). Ten years on: A longitudinal study of families of children with autism. *Journal of Intellectual & Developmental Disability*, 27, 215–222. doi:10.1080/1366825021000008639
- Hall, H. (2012). Families of children with autism: Behaviors of children, community support and coping. *Issues in Comprehensive Pediatric Nursing*, 35(2), 111–132. doi:10.3109/01460862.2012.678263
- Hartley, S., Barker, E., Seltzer, M., Floyd, F., Greenberg, J., Orsmond, G., & Bolt, D. (2010). The relative risk and timing of divorce in families of children with an autism spectrum disorder. *Journal of Family Psychology*, 24(4), 449–457. doi:10.1037/a0019847
- Hastings, R., & Brown, T. (2002). Behavioural knowledge, casual beliefs and self-efficacy as predictors of special educators' emotional reaction to challenging behaviours. *Journal of Intellectual Disability Research*, 46, 144–150. doi:10.1046/j.1365-2788.2002.00378.x
- Hastings, R., Kovshoff, H., Ward, N., Espinosa, F., Brown, T., & Remington, B. (2005). Systems analysis of stress and positive perceptions in mothers and father of preschool-children with autism. *Journal of Autism and Developmental Disorders*, 35(5), 635–644. doi:10.1007/s10803-005-0007-8
- Higgins, D., Bailey, S., & Pearce, J. (2005). Factors associated with functioning style and coping strategies of families with a child with an autism spectrum disorder. *Autism*, 9(2), 125–137. doi:10.1177/1362361305051403
- Jarbink, K., McCrone, P., Fombonne, E., Zanden, H., & Knapp, M. (2007). Cost-impact of young adults with high-functioning autistic spectrum disorder. *Research in Developmental Disabilities*, 28(1), 94–104. doi:10.1016/j.ridd.2005.11.002
- Kaminsky, L., & Dewey, D. (2001). Siblings relationships of children with autism. *Journal of Autism and Developmental Disorders*, 31, 399–410.
- Khanna, R., Madhavan, S. S., Smith, M. J., Patrick, J. H., Tworek, C., & Becker-Cottrill, B. (2011). Assessment of health-related quality of life among primary caregivers of children with Autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 41, 1214–1227. doi:10.1007/s10803-010-1140-6

- Lantos, J. (2007). The edge of the known world. *Health Affairs*, 26(2), 510–514. doi:10.1377/hlthaff.26.2.510
- Ling, C., Mak, W., & Cheng, H. (2010). Attribution model of stigma towards children with autism in Hong Kong. *Journal of Applied Research in Intellectual Disabilities*, 23(3), 237–249. doi:10.1111/j.1468-3148.2008.00456.x
- Little, L. (2002). Differences in stress and coping for mothers and fathers of children with Asperger's syndrome and nonverbal learning disorders. *Pediatric Nursing*, 28, 565–583.
- Muhle, R., Trentacoste, S., & Rapin, I. (2004). The genetics of autism. *Pediatrics*, 113(5), e472–486. doi:10.1542/peds.113.5.e472
- Myers, B., Mackintosh, V., & Goin-Kochel, R. (2009). "My greatest joy and my greatest heart ache:" Parents' own words on how having a child in the autism spectrum has affected their lives and their families' lives. *Research in Autism Spectrum Disorders*, 3(3), 670–684. doi:10.1016/j.rasd.2009.01.004
- Neely, J., Amatea, E., Echevarria-Doan, S., & Tannen, T. (2012). Working with families living with autism: Potential contributions of marriage and family therapists. *Journal of Marital & Family Therapy*, 38(1), 211–226. doi:10.1111/jmft.2012.38.issue-s1
- Neely-Barnes, S., Hall, H., Roberts, R., & Graff, J. C. (2011). Parenting a child with an Autism spectrum disorder: Public perceptions and parental conceptualizations. *Journal of Family Social Work*, 14, 208–225. doi:10.1080/10522158.2011.571539
- Newsom, C., & Hovanitz, C. (2006). Autistic spectrum disorders. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 455–511). New York, NY: Guilford Press.
- Pozo, P., Sarria, E., & Brioso, A. (2011). Psychological adaptation in parents of children with autism spectrum disorders. In M. R. Mohammadi Ed., *A comprehensive book on Autism spectrum disorders* (pp. 107–130). Open Access: In-Tech. Retrieved from <http://www.intechopen.com/books/show/title/a-comprehensive-book-on-autism-spectrum-disorders>
- Ramisch, J. (2012). Marriage and family therapists working with couples who have children with autism. *Journal of Marital & Family Therapy*, 38(2), 305–316. doi:10.1111/jmft.2012.38.issue-2
- Ramisch, J., Onaga, E., & Oh, S. (2014). Keeping a sound marriage: How couples with children with autism spectrum disorders maintain their marriages. *Journal of Child & Family Studies*, 23(6), 975–988. doi:10.1007/s10826-013-9753-y
- Ramisch, J., Timm, T., Hock, R., & Topor, J. (2013). Experiences delivering a marital intervention for couples with children with autism spectrum disorder. *The American Journal of Family Therapy*, 41(5), 376–388. doi:10.1080/01926187.2012.713816
- Seltzer, M., Krauss, M., Orsmond, G., & Vestal, C. (2001). Families of adolescents and adults with autism: Uncharted territory. In L. M. Glidden (Ed.), *International review of research on mental retardation* (Vol. 23, pp. 267–294). San Diego, CA: Academic Press.
- Sivberg, B. (2002). Family system and coping behaviors: A comparison between parents of children with autistic spectrum disorders and parents with non-autistic children. *Autistic*, 6, 397–409. doi:10.1177/1362361302006004006
- Solomon, A., & Chung, B. (2012). Understanding autism: How family therapists can support parents of children with autism spectrum disorders. *Family Process*, 51(2), 250–264. doi:10.1111/j.1545-5300.2012.01399.x
- Turns, B., & Springer, N. (2015, March 30). Families living with ASD: Integrating MFTs in Systems of care. *Family Therapy Magazine*, 14(2), 12–16.
- Woodgate, R., Ateah, C., & Secco, L. (2008). Living in a world of our own: The experience of parents who have a child with autism. *Qualitative Health Research*, 18(8), 1075–1083. doi:10.1177/1049732308320112