ORIGINAL ARTICLE

Solution-focused brief therapy with people with learning disabilities: a case study

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Summary

Whilst solution-focused brief therapy (SFBT) has become a widely used form of psychotherapy in the UK, there is little published writing on its use in services for people with learning disabilities. This article briefly discusses SFBT's potential uses with this client group, and provides by way of illustration a case example of its application with a man with mild learning disabilities referred to a learning disability clinical psychology service for 'anger management'.

Keywords *Case study, challenging behaviour, learning disability, psychotherapy, solution focused brief therapy, technique*

Introduction

Historically there has been little impetus to utilize the 'talking therapies' directly with adults with learning disabilities (Bender 1993), apparently because of views that such people are unlikely to be able to benefit from this type of intervention (Hollon 1984). However, over the last 15 years there have been a number of initiatives to engage adults with learning disabilities in various forms of one-to-one psychotherapy. As a result there is now a growing literature on working directly with this client group using a number of approaches, including psychodynamic psychotherapy (e.g. Sinason 1992) and the cognitive-behavioural therapies (e.g. Kroese *et al.* 1997).

Social constructionist philosophy (see Gergen 1999 for an outline) can provide a fresh perspective on the way that people function in society through its explicit recognition of the role of power in communication and the construction of meaning. A number of authors have identified that there is likely to be a particular utility in employing this philosophy in work with people with learning disabilities (e.g. Clegg 1993; Pote 2000), as this group of people have traditionally been devalued by society and are often seen as having little power. Psychotherapeutic approaches based on this philosophy may be especially helpful, as they offer the opportunity for people to reconstruct views of themselves and their problems in more helpful ways.

Solution-focused brief therapy (SFBT) is a form of therapy that is explicitly based upon a social constructionist philosophy, and has a number of attributes that make it attractive for use with people with learning disabilities. These include focusing on skills rather than deficits, producing a unique intervention for each client based upon their particular skills and needs, and providing the client with 'expert status' (and hence a sense of self-efficacy) within the therapeutic relationship.

Within professions employing psychotherapy in the UK, SFBT continues to grow in popularity as a model for intervention [O'Connell (1998) and George *et al.* (1999) provide comprehensive introductory readers on SFBT]. Whilst there have been few well-controlled efficacy studies conducted to date, the research that has been published provides preliminary support for SFBT being an effective tool in helping people with psychological problems [Gingerich & Eisengart (2000) and MacDonald (2003) provide reviews].

Despite being a popular model of psychotherapy with an underpinning philosophy that may be particularly helpful to people with learning disabilities, there has been very little published writing on the use of SFBT in learning disability services. A literature search reveals a total of two articles on the subject. Rhodes (2000) writes a brief account of the use of SFBT with residential staff supporting adults with learning disabilities and challenging behaviour. Stoddart *et al.* (2001) discuss their adaptation of SFBT techniques for direct use

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with learning disabled adults, and present a brief outcome study suggesting that its effectiveness was broadly equivalent to the 'longer-term psychotherapy' utilized with other learning disabled clients attending their service.

A number of practitioners in the UK and elsewhere are now showing interest in adapting and using the SFBT model in their direct work with people with learning disabilities. My own use of the model with this population continues to develop as I learn more about what works from my clients. The following case example is intended to illustrate some of the ways that I have found the SFBT approach to be useful in helping my clients, whilst hopefully provoking further discussion and interest in the use of SFBT with this client group.

Case example

Background

'Dave' (not his real name) is a 45-year-old man with mild learning disabilities. He lives alone but receives help from a support worker for several hours a week, who assists him in his weekly shopping, domestic chores and managing his finances. He does not smoke or drink alcohol. He was referred to our clinical psychology service following discussions with his support worker about problems he had had for many years in becoming aggressive with other people at his workplace, at social events, and with people in the community.

When I first met Dave, he and his support worker reported that he had been involved in three physical fights within the last 6 months. In the previous year he had been involved with police because of this aggression on about twelve occasions, having assaulted a police officer during at least one of these incidents. He had spent several nights in police custody following these events, but had never been prosecuted. He had a reputation amongst people who knew him as a troublemaker, and he reported that many people avoided talking to him or including him in things because of his 'short fuse'. He had recently been suspended from his supported work placement because of allegations that he had physically assaulted a female colleague.

Intervention

Dave was seen at his request together with his support worker. He appeared deeply ashamed of his behaviour and reluctant to discuss it when we first met. Much of our first two sessions were spent in *problem-free talk* (a description of italicized terms appears in Table 1). This revealed that despite his difficulties with aggressive behaviour, he had used his social skills to obtain a substantial social network. He attended a number of local clubs in the evenings, and helped to organize a local meeting group for his peers.

Despite his learning disability, Dave had also somehow managed to survive for a number of years without any form of help, until his support worker had been provided about a year and a half previously. He had a number of hobbies and interests, including being an avid football fan. He also managed to take day trips away most weekends.

Scaling questions were used with Dave looking at his *preferred future*. Physical 10-point scales were drawn out, and Dave's current level of control and his goal level of control were marked on them. He identified his goals as to get on better with people and not upset them, to be able to go out where he chose without worrying that he might end up in a fight, to be able to return to work, and to manage to get on well with his colleagues without frequent arguments once he returned.

Table 1 A brief description of cited SFBT terms and techniques

SFBT term	Description	Function
Problem-free talk	Time spent specifically focused upon discussion about issues other than the client's referred problem	To engage the client, help identify client's resources, strengths and interests, so that these may be utilized to help overcome the referred problem
Scaling question	Client is asked to rate their problem and goal on a scale, and to describe other points on the scale	To quantify the problem and goal in terms of behaviour and thought, and to assist in identifying concrete steps toward achieving the goal
Preferred future	Client's description of a future where the problem is absent or more manageable, in terms of positive differences in the client's life	To assist in clarifying goals and to provide motivation for change, by focusing on a positive (rather than absence of a negative) outcome
Videotalk	Description of a problem situation or preferred future in terms of concrete (visual and auditory) details	To focus attention of the client and therapist on observable behaviour and other factors that could be changed as part of a solution strategy
Exception seeking	Investigation of occasions when the problem was absent from the client's life	To identify the factors that impact upon the presence or severity of the problem, including pre-existing client-strategies for dealing with the problem, so that these can be employed as part of the intervention

During the initial session some time was also spent using *videotalk* to describe the circumstances surrounding the referred problem. This kind of conversation serves the purpose of focusing the client's attention on the concrete details of the problem situation, in preparation for *exception seeking*. Dave was able (when asked) to outline a number of characteristics of the sort of situation in which he was likely to become aggressive, and to identify the warning signs that he was about to lose his temper.

Relatively little time was spent discussing the 'problem' with Dave (the above information is basically the sum of our discussions on this subject). Instead, time was spent *exception seeking*, where we discussed occasions where the triggers that usually led to him being aggressive had been present, but he had somehow managed to control his behaviour. Dave was initially able to identify only one or two such instances. However, when we discussed them in detail (using some role-play to re-construct the situation in order to provide a trigger for memory) he identified a number of things that had helped him 'keep his cool', as well as some things that others did in an attempt to help that were actually likely to make the situation worse. For example, he reported that reminding himself of the consequences of past losses of temper helped him, as did removing himself from the situation. Conversely, others telling him to 'go away, count to ten and then come back' had a negative effect.

Interventions in SFBT are constructed by utilizing strategies that have worked for the client in the past. I therefore asked Dave to try to apply the successful techniques he had described in difficult situations over the next few weeks in order to see if they helped him control his behaviour. We also agreed that his support worker would discuss the techniques and how he had successfully used them with him when they met between therapy sessions, as an aid to Dave's memory, and to help motivate him to re-use the strategies that proved effective for him.

At our third meeting Dave reported that he had not been involved in any aggressive incidents in the previous 2 months. He had decided to talk to a number of friends and associates as well as staff at the clubs he attended about what he had found worked and what didn't. He told us about incidents when he had been sorely provoked, how he had dealt with this, and how others had noticed and even congratulated him on his control (providing social reinforcement for his new behaviour). During the session he was able to provide further examples of things he had done differently in the trigger situations that seemed to have helped him control his behaviour. Therapeutic intervention consisted of highlighting the successes, helping Dave clarify what had worked, encouraging him to do more of it in the future, and marking his progress on the scales.

Dave was seen on a total of five occasions over the course of 11 months, for between 60 and 90 min on each occasion. Despite this fairly minimal level of involvement, at follow up (9 months after discharge) Dave had not initiated any incidents of physical aggression since he was first seen, due to his application of his own resources to assert control over his behaviour.

Discussion

Traditional SFBT can be a fairly structured affair, with a range of techniques being used at certain points within a session to help maximize the possibilities for change. However, with the learning-disabled client group my experience has been that this is usually unnecessary and often confusing for the client. Rather I have found that most clients who find SFBT helpful do so primarily because of the use of a single technique. In Dave's case this appeared to be the idea of finding exceptions to the problem behaviour and doing more of what helped create those exceptions. However, I have found that the aspect of the approach that people find works for them is different for each individual.

At first glance, the process of therapy used with Dave may appear no different from that conducted when using other models of therapy. However, what is distinct in the use of SFBT is the underlying approach to the problem. SFBT theory states that understanding the original cause is not a necessary precondition to identifying an effective solution to a problem. This is why far more time in therapy sessions is spent focusing on the present and future (as opposed to the past) and on the client's strengths and resources (as opposed to the problem) than in other therapeutic approaches. Spending time on these types of discussion can also have the practical advantage of helping the therapist form an early therapeutic alliance with the client that otherwise might prove difficult to establish. For example, if my first session with Dave had been spent discussing the problem in detail in an attempt to understand its putative cause, he might well have been so embarrassed that he may not have returned, or may have spent his mental energies trying to escape from the session rather than engaging with it.

SFBT also encompasses the philosophy that only the minimum amount of intervention required in a person's life should be undertaken. This can be seen in the current case in the fact that only Dave's own strategies were utilized in the intervention. This was intended to provide Dave with feelings of self-efficacy and to enable him to commit to the method that he used to change his behaviour. It should also be noted that no assumptions were made at any of the sessions that further help would be required. Allowing Dave to determine the frequency and duration of sessions is likely to have given him further ownership over any changes, and also (as I tend to find with most people that I use SFBT with) resulted in only minimal contact with the therapist before discharge. Clients discharged from our

service are always offered the option of either a follow-up appointment or to contact us if they feel they need further assistance in maintaining progress. In Dave's case, having had his support worker involved with the therapy process enabled him to access regular reminders of his successful strategies once therapy had finished, and provided him with someone who could prompt him to ask for further help from our service in the future, if this became necessary.

It should be noted that not all clients respond as quickly and easily to the use of SFBT as Dave did. However, I have found the frequency of cases where people do respond to this approach and quickly make changes to improve their lives surprisingly high. Further outcome research examining the efficacy of SFBT with people with learning disabilities is needed to provide empirical support for these clinical observations. As many solution-focused techniques need to be adapted for use with people with learning disabilities, research to help identify what elements of the therapy (if any) work well would also be beneficial. It is my hope that this paper promotes further discussion, investigation and application of the SFBT model in work with people with learning disabilities.

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