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Stoddart, Kevin P;McDonnell, Janet;Temple, Valerie;Mustata, Alina
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IS BRIEF BETTER? A MODIFIED BRIEF SOLUTION-FOCUSED THERAPY APPROACH FOR ADULTS WITH A DEVELOPMENTAL DELAY

KEVIN P. STODDART, M.S.W., R.S.W.
Surrey Place Centre

JANET McDONNELL, M.S.W., R.S.W.
Nelson Marlborough Institute of Technology

VALERIE TEMPLE, M.A.
Surrey Place Centre

ALINA MUSTATA, M.S.W., R.S.W.
Toronto East General Hospital

Although the clinical literature reports that psychotherapists have increasingly used brief solution-focussed therapy with a variety of populations, there is no mention of the use of this model with adults who have a developmental delay. This descriptive paper discusses a modified brief solution-focussed approach with clients at Surrey Place Centre and the authors' initial attempts to evaluate it. We found that our modified approach was most successful for those who were higher functioning, were self-referred, and were supported in the therapeutic process by others. Those clients with fewer presenting problems and whose problems were related to self-esteem, family, and loss also fared better overall, according to clinician ratings. Our brief therapy service was delivered in less time (mean 118 days) than service to our clients in long-term psychotherapy (mean 372 days) ($p < .001$), with less of a waiting period for service. Clients and their caregivers were satisfied with the service as reported in a six-month follow-up questionnaire when compared with both norms for the satisfaction measure used and with the responses of our clients in long-term psychotherapy. Our experience suggests that this modified approach should continue to be used with some of our clients. Advantages and disadvantages of the model are sum-

Address correspondence to Kevin P. Stoddart, Surrey Place Centre, 2 Surrey Place, Toronto, Ontario, M5S 2C2. E-mail: stoddart@aspergers.net.

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marized. The need for more sophisticated psychotherapy outcome research is emphasized given the unique needs of this population.

Brief solution-focussed therapy (BSFT) has gained popularity over the past several years in part because of its emphasis on client strengths and the development of clear and achievable goals. BSFT has been increasingly used for a wide range of presenting problems such as substance abuse (Berg & Hopwood, 1992; Berg & Miller, 1992), depression (Sundstrom, 1993), sexual abuse (Dolan, 1991), couple distress (O'Hanlon & O'Hanlon, 1994; Shoham, Rohrbaugh & Patterson, 1995), and grief (Butler & Powers, 1996). In addition, this approach has been used in a variety of milieux such as schools (Metcalf & Metcalf, 1995; Murphy, 1996), psychiatric settings (Webster, 1990; Webster, Vaughn & Martinez, 1994), and medical settings (Klar & Coleman, 1995; Booker, 1996).

There has been no discussion in the brief therapy literature of the use of this model with adults who have a developmental delay. This absence is striking given that this population presents with many emotional problems that are appropriate for psychotherapy, such as depression, and that are similar to those of people without cognitive delays (Sovner & Hurley, 1990). They experience common psychosocial stresses such as grief and loss, trauma, and life transitions (Waitman & Conboy-Hill, 1992; Stoddart & McDonnell, 1999; Hoshmand, 1985). Despite this commonality, the need for ongoing and long-term supportive psychotherapy for the adult with a developmental delay is sometimes greater than that of the nondisabled counterpart. This may be an artefact of not only their exceptional needs and "unique stress" (Fletcher, 1993), but also of the absence of naturally occurring supports such as family members and a well-developed friendship network. It is possible that these confounding issues may constitute a contraindication for a time-limited psychotherapeutic approach with this population. Conversely, one of the clear advantages of a BSFT approach with this group is the emphasis on client strengths and empowerment (DeJong & Miller, 1995). Though this emphasis is a critical component of all therapeutic relationships, for individuals with developmental delays the issues of empowerment (Blotzer & Richard, 1995) and self-determination (Johnson, 1999) in the therapeutic encounter are particularly significant given our clients' common experiences of marginalization in society.

This descriptive paper discusses the use of BSFT with clients of the Adult Services Division at Surrey Place Centre in Toronto, Canada. This agency is a multidisciplinary setting that assesses and treats individuals with developmental disabilities across the life span. The Adult Division works with individuals who are 23 years and older and with those who support them. For the purposes of this discussion, and reflective of the adults whom Surrey Place Centre serves, our population can be described according to the diagnostic criteria for mental retardation in the *DSM-IV* (1994). These criteria are: (1) sub-average intellectual functioning, (2) significant limitations in adaptive functioning, and (3) onset

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before 18 years of age. Individuals with a mild cognitive impairment have an IQ level of 50/55 to approximately 70. Those with a moderate delay have an IQ of 35/40 to 50/55. Severely affected individuals score 20/25 to 35/40. Those who score an IQ of 20/25 and below are diagnosed with profound mental retardation.

In this paper, we will briefly summarize the literature on psychotherapy with individuals with developmental delays, describe the BSFT Project at Surrey Place Centre along with our modifications to this approach, and discuss our initial attempts at outcome evaluation. Finally, we will review our clinical and research findings and suggest some strengths and limitations of BSFT in addressing the unique psychotherapy needs of this population.

PSYCHOTHERAPY WITH INDIVIDUALS WHO ARE DEVELOPMENTALLY DELAYED

Historically, there was a consensus by clinicians that psychotherapy was ineffective when used with persons with developmental delays due to their cognitive limitations (Matson, 1984; Prout & Cale, 1994). Matson (1984) notes that even recently "many clinicians interested in mental health consider treatment of those with mental retardation well outside their purview" (p. 170). The failure to show the effectiveness of psychotherapy empirically might be explained by methodological flaws in these studies (Prout & Strohmer, 1994; Prout & Cale, 1994). More recent research and clinical experience have shown that individuals with milder degrees of cognitive impairment can benefit from individual, couple, family, and group psychotherapy (Waitman & Conboy-Hill, 1992; Prout & Strohmer, 1994; Fletcher, 1993; Harris, 1995). Hollins, Sinason, and Thompson (1994) argue that even involvement with individuals who are more severely impaired does not rule out the efficacy of a psychotherapeutic approach. Psychotherapy may be especially helpful for those affected by both a developmental delay and a psychiatric diagnosis (Fletcher, 1993). It has been noted that the population with developmental delays needs to be assessed for a wide range of emotional and psychiatric problems (Sovener & Hurley, 1990; Hurley & Sovener, 1992).

Many clinicians (Fletcher, 1993; Prout & Strohmer, 1994; Harris, 1995) have recommended modified therapeutic approaches in working with individuals who have developmental delays. Specifically, intervention should be consistent with the client's developmental level; this requires keeping vocabulary basic, using syntactically simple language and concrete examples, and supplementing language with pictures to maximize the client's understanding. The therapist needs to set the structure, limits, and boundaries for the work together and explain the therapeutic process clearly. The therapeutic process often needs to be more directive for the individual with a developmental delay. Flexibility in the delivery

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of therapy is important as well. For example, more frequent and shorter sessions may be necessary for this population. Significant people in the individual's life should be involved in the therapeutic process because adults with developmental delays are often more dependent on others for care. The involvement of others may entail providing information, aiding with interventions, and giving support throughout treatment. It is necessary for the therapist to treat the adult at his or her own developmental level and to acknowledge and encourage mastery of particular life experiences to avoid infantilizing the client and increasing dependency.

Szymanski (1980) suggested that the goals of psychotherapy for individuals with a developmental disability include: understanding and accepting their disability, improving tolerance to frustration, developing impulse control, expressing emotions appropriately, increasing independence, addressing poor self-esteem, coping with stress, and learning social skills.

DESCRIPTION OF THE SURREY PLACE BSFT CLINIC

The first two authors used BSFT informally for several years with our clients before the start of the clinic. Both therapists completed a local internship in strategic therapy that included instruction in solution-focussed therapy, attended conferences on solution-focussed therapy, and regularly reviewed recent publications on the topic. We felt optimistic about the use of this approach with our clients and thought that establishing a clinic would assist us in the formal evaluation of its effectiveness, as well as affording us the opportunity to contribute to the literature. Clients referred to the clinic were to receive only therapy services at Surrey Place Centre, as distinct from therapy in conjunction with other services. We felt this differentiation was important so that we could attend more carefully to the possible effects of the brief therapy intervention exclusively, without outcomes being confounded by client involvement in other services.

The brief therapy team met every two weeks to review case progress and see the clients in therapy. The team consisted of two senior social workers, a research analyst, and two graduate social work students. Initial sessions often included interviewing the referral source and/or significant people in the individual's life as was deemed appropriate. The assigned therapist conducted the interview with the client and others while the second therapist, graduate students, and research analyst viewed the interview from behind a one-way mirror. Persons behind the mirror were introduced to the client before the session began. Most often, our clients were pleased to have the support and assistance of other professionals; although some of our clients did not consent to be viewed by others. Clients were told that they could have up to eight sessions at this clinic (though a few more were possible if required) and that if many more sessions

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were necessary, they would be transferred into the Adult Division's long-term psychotherapy service. At least once during every interview the therapist would take a break to discuss the session with the team. This occurred to ensure that the therapist was using solution-focussed interventions as much as possible and to provide the therapist with overall direction and guidance about the case. The team occasionally requested that the therapist consult with them, or one of the team members would briefly enter the therapy room to introduce an intervention or give direction from the team members.

MODIFICATIONS TO THE SOLUTION-FOCUSSED APPROACH IN OUR CLINIC

We made a number of modifications to the brief solution-focussed approach as described by deShazer and coworkers (1986) and others (Miller, Hubble, & Duncan, 1996) because of the specific needs and abilities of our clients. One such modification was the development of exclusion criteria (see Figure 1) to determine which clients were most appropriate for the brief service. In addition, we wanted to start with small changes in the way we conducted therapy with our clients. It was clear to us that some of our clients needed longer-term assistance and support from a therapist because of the severity or chronicity of their needs and that these clients should be excluded from the project. Although we recognized that solution-focussed therapy could be helpful for these clients, it was not the *primary* approach we felt we needed to take. To maximize our success with this approach, we chose to begin with situations and problems that we felt were relatively uncomplicated and that they may not have traditionally required long-term intervention.

Figure 1. Exclusion Criteria for Participation in Brief Therapy

1. More than psychotherapy service is required.
2. There are ongoing and serious mental health concerns (e.g., psychosis, depression, schizophrenia, and bipolar disorder)
3. Client is suicidal or homicidal.
4. A risk assessment excludes the client from Surrey Place Centre due to concerns about health and safety of clients and staff.
5. The referral problem indicates a need for long-term intervention (e.g., recently disclosed sexual abuse, eating disorders, and agoraphobia).
6. There are outstanding court charges.
7. There are multiple serious problems to be addressed in psychotherapy.

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The use of numerical scaling was a difficult issue for us to address with our clients because some of them did not understand number concepts. The abstract idea of a continuum was sometimes difficult for them to grasp. A modification in our scaling technique, therefore, was to simplify the number concepts used, if they were used at all. For example, we would sometimes use a visual three-point number scale instead of a 10-point scale. We also found the use of pictures helpful. The therapist drew faces at points on a scale indicating happy or sad. Alternatively, pictures of peoples' faces depicting points along the scale were cut out of magazines. In our work, it was very important for us to behaviorally operationalize the concepts that we were scaling and specify how the idea would vary across points on the scale. For example, we would ask: "What would you be doing if you were a three on this scale?" This confirmed that our clients understood the numerical points along the scale, and it made the exercise less abstract. We also discovered that our clients often did not understand points along a *horizontal* scale. Instead, they were more able to relate to a *vertical* scale or benefit from a concrete example such as a thermometer. Another approach that we used was to draw a circle for the client and ask them to divide it into sections indicating the amount of happy feelings versus the amount of sad feelings that they had. This would be compared with previous or later depictions of the same issue.

Our first realization when we introduced the idea of homework to our clients was that many of them associate homework with past negative school experiences. We were careful in our use of this word, preferring to describe the assignment as an exercise or practice between sessions. It was important that assignments be written down for our clients because of their difficulties remembering details. Exercises were often discussed with others supporting the clients who would ensure that they understood the task and completed it before the next session.

The use of other professional and family supports in therapy was extremely important not only in ensuring that the between-session assignments were done, but also in defining the problems to be addressed, supporting the middle phase of work, and in facilitating the termination process. Many of our clients were referred by other professionals such as Adult Protective Service Workers. Our clients were not always as aware of the difficulties that needed to be addressed in therapy or articulate enough to fully describe them. Collaborators were therefore more useful than would be the case in treating cognitively normal clients.

In addition, we needed to reformulate the miracle question for our clients to understand. Typically, due to cognitive deficits, our clients had difficulty thinking about a future time when the problem did not exist and the possible reasons for this. In simplifying this, we asked them what their wish for therapy was, what their wishes for their life were, or how they would know when therapy was finished. Again, it was important for us to seek the opinion of others involved in the individual's life or support system in this matter.

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One of the issues that has to be considered in working with individuals with developmental delays is their tendency to want to please others by saying things they think that caregivers want to hear. Because of this, when rating change or improvement, we emphasized that we wanted to hear what they *honestly* felt the state of the problem was. In stating a numerical value we also asked that the point on the scale be operationalized. So, for example, if the client indicated that the problem was at "a three" instead of "a two," we asked what made it that way or what had changed for them to indicate that their problem had improved. We also asked the client to scale the problem at the beginning of the session and at the end of the session. Our rationale in doing this was to account for any changes in feelings that may have been due to therapist interventions or influence during the session.

EVALUATION OF THE APPROACH

After a one-year period, an evaluation of the BSFT approach at Surrey Place Centre was undertaken. The evaluation had four major objectives:

(a) to establish the characteristics of clients who would benefit most from this type of therapy:
   (i) their level of cognitive functioning,
   (ii) the extent of their supports, and
   (iii) whether they were self-referred or referred by others;
(b) to investigate the nature and number of client problems that were best treated using this model;
(c) to determine the extent of satisfaction with this therapy method when compared with standardized norms and to measures of satisfaction of our clients in the long-term therapy stream; and
(d) to compare the length of brief therapy to long-term therapy.

To investigate these questions, we reviewed client records to extract demographic characteristics, administered satisfaction surveys, and randomly chose long-term therapy control groups. Each of these procedures and the accompanying findings are further described. Clinicians also rated the degree to which the outcome of therapy was successful. This entailed all clinicians who were involved in the client's therapy (either directly or as observers) rating each outcome individually on a 5-point Likert style scale. In a majority of the cases there were three clinicians rating each outcome (1 = unsuccessful, 2 = poor, 3 = moderate, 4 = good, 5 = very successful). In situations where there was disagreement, ratings were discussed by the team until a consensus was reached. The resulting rating was then used to compare clients on the dimensions discussed below.

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DESCRIPTION OF CLIENTS

Over a one-year period, 29 clients were referred to brief therapy. Of these, 16 completed therapy and were deemed eligible for evaluation. For the 13 who did not complete therapy, five withdrew their request for service, five were redirected to other types of therapy (i.e., long-term or group), two left brief therapy after one or two sessions, and one continued to be seen in the clinic at the time of writing this paper. Of the 16 clients who completed brief therapy, 12 were in the mild range of cognitive delay, and four were of the borderline intellectual functioning. Two clients with a moderate level of disability were referred to brief therapy, but neither completed the service. Twenty females and nine males were referred to therapy; of these, 50 percent of the females and 66 percent of the males completed the brief intervention. As for supports, of the 29 people referred to brief therapy, 19 had the social support of both their family and a paid worker, six had worker support only, three had no worker or family support, and one had family support only. Referrals to the clinic were made by support workers in 17 cases, an internal referral in three cases (i.e., another clinician within the Centre), and other sources in three cases (e.g., family doctor, hospital). Six clients were self-referred.

CLIENT CHARACTERISTICS ASSOCIATED WITH MOST SUCCESSFUL OUTCOMES

The level of cognitive functioning of clients appeared to be related to outcome in therapy. Those with a mild level of delay had an average clinician rating of 3.25, whereas those with a borderline level of delay had a rating of 4.50. As was noted previously, the two individuals with a moderate delay did not complete therapy. These findings were also confirmed by our overall clinical impressions of therapy outcomes during the period of this evaluation project. Clinician ratings of success were also found to be significantly correlated with the level of social support available to the client. Those with the support of both family and a paid worker were rated more successful in brief therapy ($r = .55$, $p < .02$). Clients who were self-referred had higher overall clinical ratings than those who were referred by others. Self-referred clients had a mean clinician success rating of 4.25, while those who were referred by others had a mean score of 3.30. Although the difference between these scores is not statistically significant, it may be clinically relevant.

NATURE AND NUMBER OF PRESENTING PROBLEMS ASSOCIATED WITH MOST SUCCESSFUL OUTCOMES

The first column of Table 1 lists the types of client problems addressed in brief therapy. (As some clients came to therapy with more than one problem, the total

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Table 1. Presenting Problems and Success Ratings

Problem Description	Frequency[a]	Mean Success Rating[b]
Social skills/assertiveness	8 (24.2%)	3.5
Couples conflict	6 (18.2%)	3.2
Anger management	5 (15.2%)	3.4
Depression/anxiety	4 (12.1%)	3.3
Bereavement	3 (9.1%)	3.7
Sexual issues	2 (6.1%)	3.5
Occupational issues	2 (6.1%)	3.5
Self-esteem	1 (3.0%)	5
Family issues	1 (3.0%)	4
Independence issues	1 (3.0%)	2

Note: [a]Total frequency is greater than number of subjects as some subjects presented with more than one presenting problem
[b]Ratings: 1 = unsuccessful, 2 = poor, 3 = moderate, 4 = good, 5 = successful

number of problems exceeds the total number of clients.) The three most frequent presenting problems were deficiencies in social skills and assertiveness, couple issues, and anger management. Clinician ratings of success were calculated for each type of presenting problem, resulting in the second column of Table 1. Using this method of evaluation, the problems of poor self-esteem, family relationships, and bereavement were most successfully addressed in brief therapy, whereas depression and anxiety, couple conflict, and independence issues were the least successfully ameliorated. The correlation between the number of presenting problems and clinician rating was $-.51 (p < .05)$, indicating that as the number of presenting problems increased, clinicians' rating of success decreased.

CLIENT SATISFACTION

Clients who completed brief therapy were asked to complete a satisfaction survey as, when appropriate, were their caregivers. Satisfaction questionnaires were administered over the telephone by a research assistant who was not directly involved in the therapeutic process. This occurred approximately 6 months after the termination of therapy. The instrument used to assess satisfaction was the Service Evaluation Questionnaire (SEQ) (Nguyen, Attkisson & Stegner, 1983). This is a scale developed for measuring client satisfaction with service in the mental health services sector. The SEQ contains eight questions regarding the helpfulness, quality, and length of services received. It also asks if the services fulfilled the client's needs and if the client would recommend these services to

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others. A four-point Likert-style scale is used to code responses on the SEQ. The authors provide evidence of reliability and validity for their scale, as well as norms based on information from a sample of mental health patients (Nguyen, Attkisson & Stegner, 1983).

Altogether, 23 SEQ satisfaction surveys were completed. The mean SEQ scores for clients in this study was 23.62, while the mean reported for the mental health patients was 24.16. The difference between these two numbers is less than one standard deviation (SD = 4.92; Nguyen et al., 1984), suggesting that the two results are very similar statistically. Our brief therapy clients consistently reported lower satisfaction for individual items on the SEQ in two areas: (a) their perception that the service met their needs, and (b) their perception that the length or number of sessions offered by the service was insufficient. Scores on these questions fell below the average score found by Nguyen et al. (1984) in their sample.

To establish whether clients seen in BSFT were as satisfied as long-term therapy clients, a control group was selected. This group was composed of only those clients who had completed regular therapy (no dropouts), as was the case for all the BSFT clients used in the comparison. The mean satisfaction rating for those receiving BSFT was 26.35. This compares favorably with the mean satisfaction rate for those in long-term therapy (mean = 24.89). These totals are not statistically different from one another. This suggests that clients and those who support them were equally satisfied with BSFT and long-term therapy. Comparing our clients' satisfaction ratings to those of the mental health patients revealed that the two groups reported similar levels of satisfaction. The overall mean for the SEQ (satisfaction scores) for all our clients (BSFT and long-term therapy) was 25.62, and the mean reported for the mental health patients was 24.16. Although tests of statistical significance could not be done in this case because the standard errors for the SEQ in the mental health sample were not available, the difference between these two totals is clearly very small.

LENGTH OF BRIEF THERAPY COMPARED TO LONG-TERM THERAPY

To explore whether brief therapy was in fact carried out in a fewer number of days than longer-term therapy, two control groups composed of clients who received regular (long-term) therapy services were chosen. The first control group provided a comparison for the waiting period before the commencement of brief therapy to that of the regular therapy service. The second control group provided a comparison for the actual length of therapy. Initially, a random procedure was used to select both control groups; however, clinical constraints did not allow all of those randomly selected to be included in the final groups. We

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do not feel that any systematic bias was introduced as a result of our deviations from random selection.

Comparisons between the waiting period for brief therapy and that for long-term therapy showed that brief therapy was delivered in less time than other forms of therapy. The mean waiting period for brief therapy was 230 days; whereas the mean waiting period for long-term therapy was 312 days ($p < .05$). The two types of therapy were also compared according to the number of days clients were registered in the service. Using these criteria, brief therapy was significantly shorter than regular therapy, with brief therapy having a mean length of 118 days and regular therapy having a mean of 372 days ($p < .001$).

DISCUSSION

In our experience, higher functioning clients seemed to benefit most from BSFT. Clients in the moderate-to-severe range of functioning may require more time for therapy because basic issues such as identifying emotions and establishing means of effective communication must precede attention to the presenting problems. As previously noted, it is often felt by others that higher-functioning individuals are most suitable for therapy (Waitman & Conboy-Hill, 1992; Prout & Strohmer, 1994; Fletcher, 1993; Harris, 1995). Refuting this impression, Hollins, Sinason, and Thompson (1994) argue that "there is no level of retardation which makes someone ineligible for psychoanalytic treatment. Such therapy relies on emotional understanding, not on cognitive skills" (p. 234). It remains to be seen through further study whether other types of therapeutic interventions are more suitable for this client population based on their degree of impairment.

Clients in this study with higher levels of social support also fared better in BSFT. Again, this is consistent with the argument that the individual with a developmental delay is often reliant on others, which needs to be considered during any treatment (Prout & Strohmer, 1994). Besides providing support and reminders to do their between-session practice, information to the therapist about the problem, possible sources of amelioration, and promotion of the client's progress, caregivers also provided another significant advantage when involved in this process.

We perceived that the caregivers were influenced by our interventions in that they began to see the resources and strengths of the client generally but also the ability of the client to resolve their specific presenting problems. It seemed that this was a liberating perception not only for the client, but also for those supporting them. Additionally, we as therapists began to reconfigure our perception of work with our clients. Though most often very rewarding, therapy with individuals with developmental delays can also be frustrating and extremely challenging. During this project, we were more clearly able to see our success with our

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clients, in part because we were more aware when goals were accomplished because they were clearly defined and achievable. This positively affected our feelings toward the work and had a positive impact on our therapeutic relationships. Similarly, Prout and Cale (1994) remind us of the vital importance of expectancy in work with individuals with developmental delays: "When counselors expect success with their clients [with mental retardation], they are not only more likely to experience success, they will engage more clients and effectuate change in a greater number of clients" (p. 106).

It appeared that those clients who were self-referred also had better outcomes. This may reflect the degree of motivation of the clients to be involved in therapy and their desire to address their concerns. Often, our clients are "dragged" to appointments by well-meaning caregivers, when the client has not fully consented to professional involvement. We believe that this is an issue in any type of therapy with our clients, not just with a solution-focussed approach. This finding may also relate to our previous finding of greater success with higher functioning clients given that these clients more often refer themselves to services.

Problems with self-esteem, family relationships, and bereavement were best addressed in brief therapy, while issues of independence, couple relationships, depression, and anxiety were least successfully addressed. Clients with clearly defined problems or fewer problems did best in BSFT. This appears to be consistent with the observation by Prout and Strohmer (1994) that our clients may experience most success in therapy with "inelegant goals" (that is, those which address the *specific* problem that brings the client to therapy) as opposed to "elegant goals" (those that will involve generalizing therapy gains to other problems and life situations). Ongoing study is needed to establish those problems that are best addressed in BSFT. Continued consideration of long-term therapy for clients with ambiguous or multiple problems is recommended.

In responding to specific questions on the SEQ, clients reported less agreement with the statement that brief therapy helped them to meet their needs, and less satisfaction with the number of sessions offered. Scores on these questions fell below the average item score reported by Nguyen et al. (1983). However, it is noteworthy that when collecting normative data for the SEQ, Nguyen et al. (1983) also found that client perceptions of having their needs met received the lowest scores overall. This suggests that the low item in this area may be an artefact of the scale itself. On the other hand, client dissatisfaction with the number of sessions offered is not so easily explained. It would appear that there may be a genuine client concern that the solution-focussed format was too brief.

STRENGTHS AND LIMITATIONS OF THE MODEL

In keeping with the previously discussed modifications to psychotherapy with individuals who are developmentally delayed, several aspects of BSFT consti-

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tute strengths in the model. First, BSFT is a highly structured, active, and directive approach. It focuses on concrete and immediate issues. The approach partializes problems by setting limited and clearly defined goals, and it fosters an early positive relationship between client and therapist. It values normalizing the client's problems and is committed to working from the client's frame of reference. By focussing on clients' strengths, BSFT empowers clients. Complimenting by the therapist serves to increase clients' self-esteem. Our BSFT service allowed clients to receive specialized services in a brief format with less of a wait for service. The therapist was able to see more clients more effectively because the intervention was focussed, time-limited, and the clients came into the Centre for service. Lastly, the goal of achieving insight into the presenting problem was minimized; some would argue that this aim has limited practicality for our clients. Overall, there was a "good fit" between our general approach with our clients, recommendations from the psychotherapy literature regarding our clients, and the BSFT model.

Despite these strengths, BSFT downplays issues that are often relevant in assessment and intervention with our clients. These may include the history of attachment and family experiences, the client's experiences of prejudice, rejection, and discrimination, the need for ongoing and long-term support (in some cases), and the requirement of teaching our clients many basic skills to sufficiently address their present and future life situations. In addition, the chronicity of a developmental disability can lead to an increased risk of relapse. Considering our experience, the number of sessions in BSFT should be increased to approximately 12. A limit of eight does not accommodate all clients, and many felt it was too short a time (as reported in the satisfaction survey). If more sessions are offered initially this may reduce the rate of cases requiring follow-up long-term therapy and may increase overall satisfaction. The continued use of "happy faces," thermometers, and other concrete methods of scaling is required in measuring outcome and satisfaction.

LIMITATIONS AND ISSUES FACED IN THE EVALUATION

There are a number of limitations to this evaluation that should be noted. We had a small sample size; therefore, it may have been difficult to detect differences between groups. This lack of statistical power implies that we may have missed some important differences or effects. Our method could only detect gross differences. As well, interactions between variables such as those discussed here (e.g., cognitive functioning and source of referral) were not considered. Only higher functioning individuals were involved in brief therapy; generalization of these findings and our experience to more severely affected individuals should therefore be undertaken with caution. The examination of brief therapy with those with moderate delays is an area for further research.

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With respect to the satisfaction surveys, the research assistant had to break down the four-point scale for the clients in many cases. (e.g., "Did therapy help you with your problems or not?" [The client answers "Yes".] "Did it help you a little or a lot?" [The client says "a lot".]) We should note that this may affect the validity of the comparison to the general population's results. Finally, control groups could not be fully random. Some clients were going through crises and it would have been unethical to distract them with surveys. Others could not manage the questionnaire's complexity. Some were excluded because clinicians believed they would be upset by inclusion in the study.

Evaluation of psychotherapeutic interventions with this population is sorely in need of more rigorous research methodology such as random assignment, control groups, homogeneity of samples, and multiple measures of outcome in the consideration of both clinically and statistically significant findings (Nezu & Nezu, 1994). It is hoped that as psychotherapy outcome evaluation for the general population improves in response to a call for empirically validated treatments (Elliot, 1998), this improvement will carry over to research with this population.

One of the difficult issues we faced in the evaluation of outcome was locating standardized instruments that would be appropriate for use with our population. Many of the inventories for evaluating mental health issues in our population are multifaceted (Hurley & Sovner, 1992). That is, they provide overall diagnostic impressions about a range of psychopathologies, rather than providing rich, focussed, clinical data using multiple indicators of specific aspects of mental health functioning such as depression, anxiety, social skill development, or interpersonal functioning. In a study such as this, it was difficult to choose one or two standardized measures to assess the outcome of therapy with such a wide range of presenting problems. In our clinical work, we have begun to use instruments of specific mental health diagnoses for children or easy-to-understand measures for adults. The appropriateness of such measures is questionable in research given that they were not initially designed for this population. Further examination of therapy outcome in this population, whether it be brief intervention or other models of treatment, needs to address this concern.

CONCLUSION

In response to the question "Is Brief Better?", a few matters are of note. First, this question may not be the most germane when deciding on a therapeutic approach for anybody, let alone our specific population of clients. The more appropriate question may be: "For what type of clients and problems is brief therapy most effective?" We feel that BSFT provides us with an additional approach in our range of approaches in the therapeutic encounter. This does not imply, however, that in some cases our model of brief therapy may not be

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exclusively used and preferred course of action. However, individuals with developmental delays may experience extremely complex and perplexing life issues that are only adequately addressed after many multidisciplinary assessments and long-term interventions. It is a relieving message for our clients to hear that they do not need yet another professional involvement for an undetermined period of time. In this project this was clearly the message that many of our clients needed to hear. We have found that our clients (and even those who support them) may fall prey to a learned helplessness in approaching their struggles. With a better sense of their own ability to solve problems, we believed they developed increased self-esteem and came to acknowledge the wealth of their own internal resources.

It appears that the field of publicly funded psychotherapy will increasingly change in response to the sociopolitical and economic forces shaping clinical practice and will become more brief, active, directive, and present-centered. Despite this in addition to the evidence that BSFT has emerged as an empirically validated approach for different types of clients and various clinical problems, there has been no previously documented use of this model with individuals who are developmentally delayed, and their families. With more clients receiving beneficial treatment over a shorter period, the economic advantages of BSFT are obvious. Moreover, an interdisciplinary range of therapists (e.g., social workers, behavioral therapists, and psychologists) could be effectively trained with a modest investment of trainer and supervision time. As standard measures of outcomes with unique populations are further employed, BSFT's credibility will increase. Continued use of this model with our specific client group, and continued evaluation of its impact considering certain client characteristics and presenting problems is certainly warranted.

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