

# Solution-focused Brief Therapy with Families Who Have a Child with Intellectual Disabilities: A Description of the Content of Initial Sessions and the Processes

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## ABSTRACT

**Solution-focused brief therapy (SFBT) is used in a range of child services but little is known about its application to families who have a child with severe or profound intellectual disabilities. This qualitative study examines SFBT with seven such families. It considers the content of sessions and the processes that occur from the practitioner's perspective. Participants' experiences are reported elsewhere (Lloyd & Dallos, submitted). A thematic analysis of seven initial sessions indicated that SFBT highlighted parents' competencies, goals and achievements. The 'miracle question' prompted a change in rapport, discussion about the impossibility of the child becoming 'normal' and a shift away from wishful thinking towards problem solving. In sessions processes emerged of empowerment, integration of the goals into the mothers' life narrative, understanding the child's abilities and clarification of the preferred future. These themes resonated with the literature on effective coping styles for these families. The cases suggest that SFBT can generate a useful parent-professional partnership. However, difficulties were encountered when a child with autism participated in the session. Consideration is given to the 'miracle question' and the inclusion of measures of self-efficacy, coping and the therapeutic relationship.**

## KEYWORDS

*children, intellectual disability, parents, solution-focused therapy*

CHILDREN WITH intellectual disabilities (ID) are defined as those with life-long impairments of intelligence and social functioning, who require more assistance with daily living tasks than age-related peers. The range of disabilities is frequently broken down into the categories of mild/moderate (typical IQ 55–70), severe (IQ 20–55) and profound (IQ below 20) (British Institute of Learning Disability, 2005; British Psychological Society,

2000). It is estimated that there are 65,000 children with severe or profound ID in Britain, who are more vulnerable to the full range of mental health disorders and life stresses than their peers (Department of Health, 2001a). Attempts are being made to reduce health inequalities for this group and ensure that all children have fair access to, and high standards of, health care (Department of Health, 1989, 2001a, 2004). Simultaneously there has been an expansion in the range of therapeutic interventions offered to people with ID and their carers, reviewed by Collins (1999) and Frankish and Terry (2003). It has included adaptations to therapies established with other populations such as individual psychotherapy, cognitive-behavioural therapy and approaches that consider the wider family (e.g. Fidell, 2000; Kushlick, Trower, & Dagnan, 1997; Sinason, 1992; Vetere, 1993). Behavioural interventions and teaching carers skills, although well-established, have developed further and integrated with interventions to address carers' attributions, beliefs and emotions (Allen, 1999; Hastings & Beck, 2004; Hudson et al., 2003). However, existing interventions are not necessarily meeting the needs of families. In a review of the views and experiences of people with ID and their families Grant and Ramcharan (2001) suggest that practitioners lack models that are likely to strengthen and enhance family care.

Solution-focused brief therapy (SFBT) is a relatively new approach that is increasingly used with families with nondisabled children. However, little is known about the application of SFBT to families who have children with severe or profound ID. This article examines SFBT with these families, and contributes to the adaptation of approaches used in mainstream services to this group. This study briefly describes SFBT, the limited literature on its use in services for people with ID and the needs of families who have a child with ID. Methods of exploring clinical sessions are briefly discussed before examining the content of initial SFBT sessions with families caring for a child with ID. The processes that occur are discussed and recommendations are made for adapting the approach for this client group and future research.

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

SFBT is a therapeutic approach derived from clinical practice rather than a theoretical model. De Shazer (1985, 1988), de Shazer et al. (1986) and O'Hanlon and Weiner-Davis (1989), experienced clinicians, identified and refined useful components from their

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1. Problems are subject to an individual client's perception and interpretation;
2. An emphasis on the past and details of the problem are not essential;
3. There are occasions when problems are less or absent (exceptions);
4. Practitioners believe that clients can make changes;
5. Small changes can have an important impact;
6. Resistance is not a useful concept, clients co-operate in different ways;
7. The client's goal is central.

Figure 1. Core assumptions of SFBT.

Source: Adapted from Beyebach (2000), George, Iveson, and Ratner (2003), and Rhodes and Amjal (1995).

consultations to develop the approach. Inevitably their theoretical and clinical backgrounds influenced the development of SFBT; these included strategic-family, brief and narrative therapies. The core assumptions of SFBT are outlined in Figure 1. In essence the approach treats the family as the expert on their own situation and is curious about successes and solutions rather than problems. The therapist adopts a respectful, nonblaming stance and works towards the client's goals, using the client's frame of reference and language. As a relatively new and developing approach the debate about the way in which SFBT is practised continues (e.g. Miller & de Shazer, 2000; Piercy, Lipchick, & Kiser, 2000).

There are many enthusiastic reports about using SFBT in mental health services for children and adolescents, with parents and in schools (Iveson, 1995; Lee, 1997; Letham, 1994, 2002; Metcalf, 1997; Rhodes & Amjal, 1995; Thompson & Littrell, 1998; Wheeler, 2001). These have included interventions with families where there are child-protection concerns and mandatory contact with services (Berg & Kelly, 2000). Wheeler (2001) suggests that its value lies in the way negative perceptions are altered, a pattern of blame is interrupted and attachment improved. Each session functions alone so the intervention may be useful for the large number of clients who only attend once (Wheeler, 2001). Additionally it appears to be useful across a range of ethnic groups (Concoran, 2000).

Despite enthusiasm for SFBT the evidence base supporting it is limited. Controlled studies indicate that training staff in SFBT has a positive impact on the way they interact with clients (Bowles, Mackintosh, & Torn, 2001; Sundman, 1997). Gingerich (2001) and Gingerich and Eisengart (2000) reviewed controlled-outcome trials of SFBT and suggested that it is as effective as standard interventions. However, this conclusion is only tentative as it was drawn from a small number of controlled outcome studies with diverse client groups. Stalker, Levene, and Coady (1999) urge practitioners to be cautious when applying the SFBT model to new client groups. It is not clear whether findings from existing research and case material will generalize to families supporting a child with ID as they often present with different complex needs and ethical issues.

### **Solution-focused brief therapy in intellectual disability services**

SFBT is beginning to be explored in services for people with ID; see, for example, Bliss (2002). Stoddart, McDonnell, Temple, and Mustata (2001) indicated that adapted SFBT was as effective as an unspecified form of psychotherapy for adults with mild and borderline ID. Students with mild ID receiving SFBT in educational settings have also shown improvements but these are not conclusive (Franklin, Biever, Moore, Clemons, & Scamardo, 2001; Thompson & Littrell, 1998). However, interventions for children with more severe ID are often family based or mediated by carers or parents. A systematic

and automated literature review conducted in preparation for this study suggests that SFBT has not yet been explored with such families. One example of the approach with paid staff caring for an adult with severe ID was traced (Rhodes, 2000). The practitioner found it a useful approach with carers; in particular the focus on strengths, the nonblaming stance and the way carers generated solutions that built on their competencies. This suggests that SFBT warrants investigation with parents caring for children with similar levels of ID. Interventions for this group tend to be underdeveloped and researched.

### **Issues for families with an intellectually disabled child**

There is a consensus from government, families and practitioners that interventions for these families need to be collaborative and take account of the needs of the carer as well as the child with ID (Cunningham & Davis, 1985; Department of Health, 1989, 1995, 1999, 2001a, 2001b, 2004). Hastings and Beck (2004) reviewed research on interventions to reduce stress in parents and concluded that, while respite packages and cognitive-behavioural therapy may reduce parents' stress, more research and clinical developments are needed. There is an implication that reducing stress may maximize the efficacy of parent training or interventions to reduce challenging behaviour.

Allen (1999) notes that parent training and behavioural interventions can effectively reduce the frequency, intensity or duration of challenging behaviour but families can find them difficult to implement. He and others (e.g. Grant, Nolan, & Keady, 2003; Shearn & Todd, 1997) recommend that these interventions take account of the multiple demands on parents, which vary across the family life cycle. They suggest that failure to do so may increase rather than reduce the demands and stresses on families. Interventions therefore need to be culturally valid, relevant to the family's circumstances and timely. Families also need adequate social and physical resources, for example, services, support and respite (Emerson, 2003).

The meaning the families give to their situation and the way they construe the stressors, their own abilities and resources, also mediates stress and compliance with advice or behavioural interventions. An association has been demonstrated between mothers' wellbeing and particular ways of thinking about the child's disability. These include self-efficacy (Hastings & Brown, 2002), perceiving the child as a source of personal growth (Hasting & Taunt, 2002), positive perceptions (Hastings, Allen, McDermott, & Still, 2002), low expressed emotion (Lam, Giles, & Lavander, 2003) and addressing problems with an active problem-solving approach rather than 'wishful thinking' (Kim, Greenberg, Seltzer, & Kraus, 2003). Olsson and Hwang (2002) suggest that 'a sense of coherence' is associated with coping. It is a construct comprised of three strands: Manageability (belief that problem behaviour can be managed), meaning attached to the caring role, and comprehensibility (an understanding of the child's abilities and situation). Self-efficacy or manageability are recurrent themes. Families reported to Knox, Parmenter, Atkinson, and Yazbeck (2000) that a vision of a hopeful future and direct, but sensitively delivered, information were conducive to a sense of control over family life.

In relation to assisting families with a child with severe ID, SFBT could, as Rhodes (2000) reflects, build on carers' strengths, and as Wheeler (2001) suggests, alter negative perceptions, interrupt a pattern of blame and assist positive attachment. It appears to also have the potential to offer culturally or ecologically valid interventions as the families' existing strategies are developed (Concoran, 2000). Data on how training in SFBT altered staff interaction styles (Bowles et al., 2001; Sundman, 1997) suggest that it is also worth thinking about as a way of relating to families for many practitioners,

who either rely on core counselling skills (Noon, 1999) or integrate techniques from a number of approaches. To gain insight into the potential of SFBT with families who have a child with ID, it is useful to examine clinical sessions in depth.

### **Methods to explore interventions**

There is renewed research interest in the processes that occur in therapy as well as measures of efficacy. Roth and Fonagy (1998) emphasize the importance of exploring the process of different forms of psychotherapy to identify common active ingredients. Research in this area has included the therapeutic relationship, the most helpful and least helpful events in appointments (Elliot & Shapiro, 1988; Llewelyn, 1988), the details of interactions in therapy (Beyebach & Carranza, 1997; Beyebach, Rodriguez Morejon, Palenzuela, & Rodriguez-Arias, 1996; Beyebach et al., 2000) and how clients make transformations or change the way they perceive a situation (see, e.g. Coulehan, Friedlander, & Heatherington, 1998; Sluzki, 1992). Such studies can make an important contribution to our understanding of how interventions and different therapies work. They are particularly useful as exploratory studies for new developments. This study focuses on the practitioners' perspective of SFBT sessions and is an example of reflexive practice. In parallel to reflexive practice practitioners are encouraged to gain insight into clients' experiences of therapy (e.g. Messari & Hallam, 2003). The parents' experiences of SFBT are reported elsewhere in an associated paper (Lloyd & Dallos, submitted).

### **Aims**

This study aims to:

- Describe the content of initial SFBT sessions with families who have a child with severe or profound ID;
- Discuss the processes that occurred;
- Describe the children's contribution to sessions in which they participated;
- Give a view of sessions from the practitioner's perspective;
- Inform others considering adopting, adapting and evaluating the approach by sharing experience.

### **Method**

#### **Design**

A case-study approach was selected to provide an indepth understanding of SFBT with a small sample of families ( $n = 7$ ), in a typical clinical context, from the practitioner's perspective. To manage the wealth of data from the cases, this study took a cross-sectional view of initial sessions for the group. In a design similar to that used by Coulehan et al. (1998) the data were organized into the phases of the sessions described in Table 2. Each phase was analysed thematically so that recurrent processes could be identified across the families. The design was influenced by quality standards for qualitative methods (Elliot, Fischer, & Rennie, 1999; Robson, 2002, p. 168; Stiles, 1993).

Only initial SFBT sessions were studied. The rationale is that first sessions have a structured format and therefore some uniformity. In SFBT each session functions alone and subsequent SFBT sessions are comprised of similar elements. Also this study represents an initial exploration of SFBT with these families; by only exploring the first session any potential but unexpected adverse effects could be minimized.

Ethical approval was obtained from the Local Research and Ethical Committee. Adult participants gave informed consent and assented on behalf of their child. All names have been changed to preserve confidentiality.

### **Context**

The study is set in a National Health Service Department for people with ID in England. Rural, suburban and inner city areas are covered. The latter has government employment, health and education action zone status indicating areas of deprivation. The population is predominantly White and British. Families can self-refer or arrange referral through a wide range of professionals.

The first author is a female British clinical psychologist, with 15 years' experience in services for people with ID and a background in learning theory. Training and supervision in SFBT led to curiosity about the relevance of the approach to families who have a child with ID. The second author, the supervisor, has a background in systemic theory and practice with children and young people.

### **Participants**

All the families ( $N = 13$ ) on a waiting list to consult with a clinical psychologist, in the ID service described earlier, were invited to participate in the study. They were invited if they had a child with a severe or profound ID, who was less than 18 years of age, and regardless of the reason for referral. Of the 13 invited, 7 families chose to participate and they are described in Table 1. Six of the children had severe or profound ID. One child, initially thought to have abilities in this range, was subsequently assessed as having a moderate ID confounded by impairments in social functioning. The families were considered similar to those routinely using the service by the clinical psychology department. Parents received a government carer's allowance indicating the severity of their child's ID and their time-consuming caring role. The families were experienced users of health, education and social services. All had seen a clinical psychologist or psychiatrist previously about their child; 5 families were referred by paediatricians and 2 self-referred. Three parents volunteered that they had been treated for stress or depression. One mother and child shared a degenerative physical condition.

### **Data collection**

The seven participating families each received an initial appointment using SFBT, outlined in Table 2, which reflects the Brief Therapy Practice training (George, Iveson, & Ratner, 2003). Six participants were able to choose the location of the appointment and who attended. Five chose home visits and one a clinic appointment. Mothers attended all of the initial SFBT appointments, one father and the two most able of the children with ID participated in parts of their sessions. A choice was not available to one family who received a clinic appointment that was attended by the mother and grandmother. Appointments lasted approximately 1 hour. They were recorded on audio-tapes, transcribed and identifying information was changed.

### **Data analysis**

The audio-tapes were discussed with the participants two weeks after the session to collect data for the study on parents' experiences of SFBT (Lloyd & Dallos, submitted). At the end of the 6 months of data collection all the session transcripts were divided into the phases of SFBT as outlined in Table 2, column 1. The data for Phase 1 for all participants was reread several times. Recurrent themes across transcripts and significant exceptions were noted; this included the participants' verbal and nonverbal behaviour.

Table 1. Description of the referred children and their families

	<i>Degree of ID</i>	<i>Mobility</i>	<i>Communication</i>	<i>Sensory impairment</i>		
Children's abilities	1 Moderate 4 Severe 2 Profound	5 Ambulant 2 Nonambulant	5 Delayed 2 Nonverbal	2 Visual 1 Auditory 2 Heightened		
Diagnosis	2 Global developmental delay and hypotonia (1 due to being a premature twin) 2 Global developmental delay and autism 2 Congenital brain damage (1 due to myotonic dystrophy) 1 Down's syndrome					
Reason for referral	3 Oppositional behaviour 3 Anxiety or depression 1 Regurgitation and bowel management 1 Sociosexual behaviour 1 Violence 1 Sleep					
	<i>Sex</i>	<i>Mean age</i>	<i>Family structure</i>	<i>Number of siblings</i>	<i>Residence</i>	<i>Parents' employment</i>
Demographic information	6 Boys 1 Girl	8 yrs range (4–14)	3 Two parents 2 One parent 2 Blended	Mean 1.4 range (0–4)	4 City 2 Town 1 Rural	6 Professional 2 Skilled 2 Manual 2 Full-time parents (2 absent fathers)
Participating mothers	Mean maternal age 41 years (range 31–54) * 4 Part-time worker 2 Full-time carer					

\* data missing for the father and grandmother who participated.

This was repeated for all of the phases of SFBT. These themes provided a description of the sessions' content. The findings were presented to a participant, a group of clinical psychologists and a group of SFBT practitioners. Significant processes that recurred across the phases were identified and discussed by the practitioner/researcher and these groups. These were checked against the original data. These overarching themes, the psychological processes that emerged across phases, are considered in the discussion as the processes occurring in the sessions.

*Checks on the quality of data and analysis* The transcripts were authenticated against the Rhodes and Ajmal (1995) description by SFBT practitioners trained by the Brief Therapy Practice in London. All the sessions met the authentication standard, in one session the conversation digressed from SFBT for a short time and this section was excluded from the analysis. All the transcripts were independently analysed by two clinical psychologists in training and a supervising clinical psychologist who identified comparable themes. If differences emerged they were resolved by referring back to the original data and discussed until a consensus was reached. As mentioned earlier the findings were presented to the authenticating SFBT practitioners, practitioners in ID and clinical psychology services independent of the study. A summary of the findings was also presented to the participants and a wider group of parents. Two of these read drafts of the project and discussed it in depth. Comments and observations from the above

Table 2. The SFBT intervention

<i>Phase of SFBT</i>	<i>Intervention</i>
1. Setting up the session	1.1 Parent given choice of location and participants. 1.2 Parent invited to set the agenda. 1.3 Problem-free talk, e.g. questions about work, life style.
2. Pretreatment change, exceptions and coping	2.1 Questions about pretreatment change, exceptions to the problem and coping. 2.2 Compliments. 2.3 Active listening.
3. Hypothetical future	3.1 The family's vision of a preferred future is elicited. 3.2 De Shazer's (1988) miracle question was used for this purpose: 'Suppose that one night when you were asleep there was a miracle and this problem was solved. The miracle occurs while you are sleeping, so you do not immediately know that it has happened. When you wake up what is the first thing you will notice that will let you know there has been a miracle?' 3.3 If the family struggled with the 'miracle question' alternatives were used, e.g. 'If I drove past in 3 months and saw things going really well, what would I see?', 'If therapy is successful what would you see?' 3.4 Prompts to elicit more detail.
4. Scaling	4.1 The family is asked to imagine a scale where 0 represents the most difficult things can be and 10 the best, then to position themselves on the scale. 4.2 Questions are asked about other points on the scale, e.g. what is stopping them drop lower, what half a point higher on the scale would look like.
5. Goals	5.1 A concrete observable goal is elicited.
6. Conclusions	6.1 Family asked how they might achieve the goal, e.g. 'If I see you when you are successful and ask you how did you do that what would you say?' 6.2 Inter-session task given to continue with successful strategies, observe exceptions or to experiment with alternative strategies and note outcomes. 6.3 Family is complimented.
7. Subsequent sessions	7. Family asked when, where and what type of subsequent session they would prefer.

were integrated into the findings with reference to the original transcripts for clarification. A research journal was kept to record reflections of the sessions and the research process in order to provide an audit trail.

### **Findings: The content of sessions**

The phases of SFBT provided a natural framework for analysing the content of sessions. Each phase was characterized by themes that occurred for several families; these are outlined in Table 3. The themes are defined and supported by extracts from the transcripts. Significant exceptions are also presented.

#### **Phase 1: Setting up the session**

*Theme 1.1: Problems discussed alongside strengths and solutions* In response to an invitation to set the agenda for the session some participants described a problem, strengths and a potential solution ( $n = 4$ ). The opening lines of Tina's session demonstrate this:

Table 3. Themes in the families' responses in each phase of SFBT

Phase of SFBT	Themes in the families responses
1. Setting up the session	1.1 Problems discussed alongside strengths and solutions. 1.2 Busy competent families.
2. Pretreatment change, exceptions and coping	2.1 Remarkable parents (skilled, committed, warm, proud, stoical and in control).
3. Hypothetical future	3.1 Change of pace and nonverbal behaviour. 3.2 Discuss a miracle of the child being normal and its improbability. 3.3 Comparison to nondisabled peers and detail of the disability. 3.4 Alternatives to the miracle question yield fuller replies. 3.5 A vision of the future is elicited which initially is vague but becomes more specific.
4. Scaling	4.1 Parents integrate the scale into their conversation. 4.2 Parents talk of possibilities. 4.3 Examples of achieving the goal are given.
5. Goals	5.1 Clarified goal or issue. 5.2 Expressed feelings, thoughts and beliefs about the goal. 5.3 The exceptions conversation is revisited and integrated with the mother's life narrative. 5.4 Spontaneously suggest ways of achieving the goal.
6. Conclusions	6.1 An inter-session task devised by the parent and practitioner together, drawing on both of their knowledge of ID and the child. 6.2 The parent took an active role in executing the plan. 6.3 The parents complimented the child and each other.
7. Subsequent sessions	7.1 The interval between sessions ranged from 2 weeks to 6 months. 7.2 A range of interventions chosen.

*P:* Where do you want to start?

*M:* Well, we have still got the problems with Joe, like his settling in, they [Education Department] wanted him to have a go in there [mainstream school] and see how he gets on. He's fine, he's coping quite well, he's going to need one-to-one. (Tina)<sup>1</sup>

*Theme 1.2: Busy competent families* Rapport-building questions were characterized by short factual replies, which built up a picture of busy, competent families ( $n = 7$ ). This included juggling skilled work, parenting other children and the adults' own health.

### **Phase 2: Pretreatment change, exceptions and coping**

*Theme 2.1: Remarkable parents* A theme emerged of remarkable parents coping with some extreme behaviour or complex disabilities with skill, commitment and warmth ( $n = 7$ ). When participants gave a problem-dominated description of their situation, questions about how they coped and compliments appeared to switch the conversation to one of stoicism and skill. To a degree these questions presupposed coping and led to problems being discussed alongside happier issues, recent improvements, achievements and endearing habits. The families spoke cheerfully and gave lengthy replies; there was a sense of pride and self-efficacy. The families often told the psychologist how to manage the behaviour; there was a sense of the parents being expert. These points are illustrated in another extract from Tina's session:

*P:* I hear you saying that there were fights and it was difficult but the way through with Joe was making it?

*M:* Making it a game. Making it so it wasn't so stressful.

*P:* So you make it a game and not stressful?

*M:* Yeah no shouting . . . I had to keep my voice at a level, you know, sometimes . . . I would have to go up about 60 times a night at one time. You know, when you're up and down, up and down, and then I would get really tired and angry and if I shouted he would start so I had to keep myself at a really steady pace and a level.

*P:* Quite an achievement when you are up and down. (Tina)

### **Phase 3: Hypothetical future**

*Theme 3.1: Change in pace and nonverbal behaviour* In all the sessions a striking change in conversational style occurred immediately after the miracle question. The pace slowed with pausing, laughter and head shaking and the tense changed from a discussion of the past and present to the future.

*Theme 3.2: Responses to the miracle question* Four participants responded with alternative words to 'miracle', for example, 'If the wand had been waved', or 'I wish to God I could just click my fingers'. Six participants said the child would be 'normal' but this was improbable:

*M:* I think you would see a normal little boy wouldn't you? (pause) I don't know. I've never, (shaking head) I don't know, I've never really seen him. (Jess)

*Theme 3.3: Comparison to non-disabled peers and detail of the disability* Three participants explained the level of their child's disability and two revisited dominant problem-focused narratives that had been replaced in Phase 2:

*M:* Oh that [miracle] would be wonderful. Oh and we should tell her that we had one year when she was sick all the time . . . terrible it was for a year . . . and now she regurgitates all the time. (Cathy)

*M:* Him being Joe, a proper little boy in the mornings like his twin . . . when you have twins you do compare and Joe being the way Joe was, it was always like having two different children in the house. You had on par a 4 or 5 year old and then you had what I remember a 3 year old. So it was a different situation totally. What [his twin] has learnt over the year Joe's sort of not quite there, but he's getting there. So I have got like a 3 year old and 5 year old. (Tina)

One mother did not consider changing the child's disability in her vision of the hypothetical future. Her hypothetical future was a vision of the adults coping:

*M:* 'Tim is just Tim . . . he is the way he is and there's a lot about being Tim that is very good. Somebody once asked me would I want Tim to get better and I said, 'well there's nothing wrong with him so I wouldn't want him to get better but I wouldn't want him to change because he wouldn't be Tim. (Alison)

*Theme 3.4: Alternatives to the miracle question yielded fuller replies* All the participants gave fuller responses to alternative means of asking about the hypothetical future:

*P:* If I met you in a theme park in a couple of months and things were going really well, what would I see?

*Theme 3.5: Vision of the hypothetical future emerges* A pattern emerged in which the parent initially said the problem would be absent, then gave a vague vision of the future which became more detailed and concrete in response to prompts ( $n = 7$ ):

*M:* He wouldn't be saying that word, it would just go away. (Jess, problem absent)

*M:* Be calmer, enjoy it and that's what I was trying to make him, you know, enjoy things. (Jess, vague vision)

*M:* If things were really good I'd be happy to leave the children to play on their own together. They'd be running around in the meadow outside maybe playing with a tennis ball or kicking a football. (Emma, specific vision)

#### **Phase 4: Scaling**

*Theme 4.1: Parents integrate the scale into their conversation* Parents immediately replied to the scaling question and the subsequent conversation was interspersed by references to points on the scale ( $n = 7$ ). The conversational style reverted to the enthusiastic style of Phase 2. The mean score on the scale was 4, with individual scores ranging from 1 to 8.

*Theme 4.2: Parents talk of possibilities* The ideas of movement on the scale and self-efficacy were implicit in the replies as the participants became aware of skills they had previously taken for granted ( $n = 7$ ):

*M:* Two to three but we could improve that . . . Maybe that's possible, she surprises you; you know it's possible, she's very shrewd sometimes. (Cathy)

*M:* I suppose we do that [signing] without even knowing we do it that way . . . I suppose we've just got in the habit of just continually doing that, because whenever we speak now we always [sign] very expert. (Jenny)

*Theme 4.3: Instance of achieving the goal cited* All the participants recognized times when they had partly achieved their goal or taken a step towards it. This recognition often occurred without prompts:

*M:* I don't think I know what relaxed is at the moment . . . I do feel relaxed on a Friday, when he goes to respite. I go to meet my friends . . . I meet the same group and I enjoy that, um, it keeps me sane. (Emma)

#### **Phase 5: Goals**

*Theme 5.1: Clarifying the goal or issue* The scaling discussion elicited a goal or at least clarified the issue the family wanted to address. The goal was related to the families' perception of the problem and linked to the miracle ( $n = 7$ ). For example the 'miracle' of speech for Kim, through the scaling exercise became a goal of her handing a symbol to an adult to communicate.

*Theme 5.2: Parents express feelings about the goal* Three mothers expressed their thoughts, beliefs and feelings about the goal and linked these to their own life stories. Attempts to move forward with the goal failed until this was acknowledged. Exceptions were revisited and integrated into the mothers' life stories. After this, these mothers took an active role in suggesting how the goal should be tackled.

An example is Jane who was sceptical her son could achieve the goal (follow a bedtime routine). Associations he had learned in the past that had been detailed in Phase 2 (exceptions and pretreatment change) were reexamined. It emerged that this learning occurred by necessity, at a time of crisis. She disclosed that she was approaching the age of 40 and was preparing to have another child. The sleep problem was not urgent but addressing it was part of her preparations. Jane suggested that dealing with nonurgent issues was novel for her. It represented an adventure. She then suggested using 'objects of reference', a classical conditioning teaching strategy which had been successful at school to teach her son about bedtimes.

### **Phase 6: Conclusions**

*Theme 6.1: A collaborative intersession task* In the last example the mother suggested how to achieve the goal. Some shared knowledge of classical conditioning and using 'objects of reference' to communicate was assumed. In the other sessions the plans drew on the practitioner's and parents' perception of the situation and knowledge of ID ( $n = 7$ ).

*Theme 6.2: Parents assumed they would take an active role* The participants assumed an active role in developing and executing the plan. This was demonstrated by Kim's family. They moved from a position earlier in the consultation where they expected the practitioner to solve a problem to the point where the family took responsibility for this:

*M:* Well I could take a sign; just a sign of the toilet so that she gives it . . .

*Gran:* You can put that on a piece of wood or something couldn't you? [to help the child to grip] . . . a building block.

*Theme 6.3: Compliments* Until this point the sessions had been characterized by the practitioner questioning and using active listening skills. The balance changed towards the practitioner summarizing the plan that became the intersession task and complimenting the family. The families then spontaneously complimented themselves and their child ( $n = 7$ ):

*M:* He's my handsome aren't you? (Emma)

*M:* She's had a wonderful childhood. Yes, yes, I read to her every night. (Cathy)

### **Phase 7: Subsequent sessions**

*Themes 7.1 and 7.2: Diversity of subsequent sessions* All the families wanted to maintain contact with the practitioner but requested a range of locations, intervals between sessions and approaches as outlined in Table 4. The range indicates the wide range of needs families present with and a desire for less frequent appointments than practitioners often offer.

#### **The two children who participated in the sessions**

Five families chose to have sessions without the child present. Steve, who has moderate ID, participated in the last 15 minutes of the session by arrangement. After persuasion to join the session, he listened to compliments, explained his perspective and was able to suggest a solution. This is illustrated by the following extract from the session:

Table 4. Choice of subsequent sessions

Location	Home	4
	Clinic	2
	Telephone contact	1
Interval	2 weeks	4
	1 month	1
	6 weeks but not required	1
	6 months but not required	1
Intervention	Skill teaching	6
	Maternal support	4
	Cognitive assessment	2

C: I'm a bit shy . . .

P: What helps you be brave?

C: Tinky winky [a TV character toy].

Grant, an adolescent with autism who had been referred because of concerns about his social and sexual behaviour, entered and left the room throughout the session. He participated in the discussion of strengths, exceptions and compliments. Visualizing a hypothetical future however, posed some difficulties. His mother's hypothetical future was a detailed description of Grant playing with a neighbour's 5-year-old daughter, only touching her hand to help her across a road (see Example 3, Theme 3.4). He focused on one small detail of the hypothetical future, taking it out of the wider social context. He only spoke of holding her hand. He also wanted the imagined future immediately and became agitated, shouting 'today' repeatedly. Grant was very interested in magic (Harry Potter books); this was used to elicit his vision of a good future but he began to shout repeatedly, 'I need a magic wand' and bang doors. His mother intervened and then explained that she had only just averted a violent outburst. Grant had a clear vision of his preferred future, to make a picture of a magical teenage female character from a book talk to him and to come to the practitioner's house. The eventual intervention included social skills sessions about interacting with peers that took place at the psychology office and placement at a boarding school.

## Discussion

The limitations of the study are outlined before a discussion of the processes that appeared to occur across cases and reflections.

### **Limitations of the study**

Case studies are often limited by their small sample size and bias to successful cases. Attempts were made to address this by including seven cases from routine clinical work. To prevent the amount of data being unwieldy a thematic analysis of intervention phases was conducted in a similar manner to Coulehan et al. (1998) and Sluzki (1992). This provides a view of the processes that occur across sessions. The study provides a rich subjective account from the practitioners' perspective appropriate for exploratory studies. A specialist in intellectual disabilities conducted the sessions and a different practitioner in a different context may have different experiences or examined the case material with a different perspective (Simon, 1996). Also case studies are noncomparative so claims

cannot be made about the efficacy of SFBT. They are examples of clinical work that enable practitioners to share experiential knowledge and insights thereby developing practice (Ashworth, 2003).

To ensure the analysis was conducted with rigour and integrity, quality checks used in qualitative research were adopted (Elliot et al. 1999; Robson, 2002, p. 168; Stiles, 1993; Turpin et al., 1997). These checks verified that SFBT was used, confirmed that the findings were derived from the data and resonated with others familiar with the issues, that is, the participants, other parents and a range of practitioners. The checks suggested that the findings were plausible and valid.

### **Empowerment**

Others, using a similar methodology, have noted shifts in participants' narratives in therapy. Coulehan et al. (1998) and Sluzki (1992) stressed that a central feature of change in their form of narrative therapy was a transformation of meaning and attribution. Importantly, Coulehan et al. (1998) added that their study showed that such change was accompanied by shifts in emotions. Other process studies have shown that a shift to a position of hopefulness is central (Roth & Fonagy, 1998; Stiles et al., 1990). In this study a similar finding emerged in relation to a sense of empowerment.

Client control and choice are inherent in a number of the SFBT components, particularly the early phases. Many other therapeutic approaches elicit the history and detail of problems. In contrast SFBT questions presume there are some exceptions and enquire about coping, managing and problem-free areas of life. There was some evidence that these presuppositional questions shifted problem-oriented conversations into ones about resilience and skills. Mothers began to develop their narratives into ones that emphasized self-efficacy and possibility. This enabled the practitioner to compliment or reinforce achievements; a juxtaposition with a commonly held view of needy families requiring sympathy and expert direction.

Some families already had a 'solution' at the outset of the session. This suggests that they wanted encouragement, reassurance or resources rather than guidance or advice. The approach appeared to enable them to articulate this. Grant et al. (2003) recommend that practitioners working with parents respect their knowledge and SFBT seems to achieve this. It is interesting that the parents chose their subsequent sessions at intervals more distant than many practitioners would offer routinely. Shearn and Todd (1997) and Grant et al. (2003) suggest that interventions need to take account of the multiple demands on the family and their stage in the life cycle. The cases suggest that SFBT provides opportunities for this, which may increase the families' sense of control. However, many families find information helpful (Knox et al., 2000; Pain, 1999). The model does not explicitly provide opportunities for the practitioner to share his or her knowledge of ID. In these sessions the practitioner and family often shared information and combined their knowledge of ID as the inter-session task was devised. This collaborative position may have been enhanced by the respect for the parents' knowledge and providing opportunities for them to articulate it earlier in the session.

This study is not alone in suggesting that SFBT may enhance self-efficacy. Beyebach et al. (1996, 2000) found an association between a strong locus of control and good outcomes and suggest that locus of control may improve over the course of SFBT. They recommend that the early phases of SFBT are emphasized. This study concurs. It is particularly salient for this client group, as Hastings and Brown (2002) demonstrated, that self-efficacy mediated the impact of a child's challenging behaviour on maternal anxiety and depression and moderated the impact on fathers. Future investigations of SFBT could usefully test the suggestion that it increases self-efficacy.

**The miracle question**

The miracle question, using specific words, is included in the research definition of SFBT (Beyebach, 2000) but it remains controversial. Butler and Powers (1996) used the question with bereaved families. They suggest, that if it is asked sensitively, it acknowledges grief and allows families to move on. In contrast Neilson-Clayton and Brownlee (2002) used SFBT with cancer patients and their families and recommend alternative ways of asking about the hypothetical future. This is in line with others' practice, for example, Letham, (2002), and Stoddart et al. (2001) who adapted SFBT for people with ID.

In this study the question seemed to generate a complex process that became clearer as it was discussed with the participants and other parents in the validation exercises. The participants' verbal and nonverbal behaviour did not suggest grief or distress but a quizzical look. The question may have been familiar as two mothers explained, during the validation exercise, that they used to hope for a miracle and others that they secretly still did. The miracle question appears similar to 'wishful thinking' in which the parent is passive and an external agent creates change. Indeed some parents responded with words associated with magical wishes. Kim et al. (2003) described 'wishful thinking' as a coping style associated with poorer relationships with the child, poorer adaptation and the mother having little control.

Six families described a 'miracle' of the child becoming normal but in the same sentence explained it was impossible. In the process of explaining how a miracle was impossible or irrelevant the families described the children's disabilities. For some this took the form of a reversion to a problem-oriented discourse. Others thoughtfully tried to make sense of their child's abilities. Four families requested cognitive assessments in subsequent sessions or revisited psychometric and language assessments that had been conducted prior to the session. This was unexpected and differed from the usual practice of the clinical psychology department. For these four families greater understanding or acceptance of their child's ability seemed a significant event that influenced placements and management; it appeared to be stimulated by the miracle question.

Alternative means of visualizing a hypothetical future were sometimes used and yielded fuller replies that became more detailed and concrete with prompts. This felt helpful and is supported by Knox et al. (2000) who report that parents find a vision of a hopeful future conducive to a sense of control over family life. It also resonates with Roth and Fonagy's (1998) and Stiles et al.'s (1990) thoughts on hopefulness being central to change across different therapies. Hopefulness appeared to emerge with the use of the rating scale. The parents quickly encompassed the idea of a scale; it appeared to contain at one end their greatest fears and negative experiences, at the opposite end the distant hope of a miracle, and the current situation. Simultaneously the families were able to imagine progress and recognize instances when they had achieved it. The conversation returned to one of possibility, change, hope and self-efficacy. It bore similarities to 'active problem solving' thinking, described by Kim et al. (2003), associated with good adaptation to the disability and good relationships with the child. One interpretation is that by considering a miracle the parents examined their wishful thinking and loosened allegiance to this coping style, before they recognized their achievements and sense of self-efficacy in the scaling task. Some parents then seemed to need to integrate the goal, the sense of self-efficacy and the understanding of the child's abilities into their own life story before moving on to the inter-session task.

The processes described bear some similarities to a 'sense of coherence', the concept identified by Olsson and Hwang (2002) that is associated with coping in families caring for a child with ID. A sense of coherence is comprised of three variables: manageability,

meaning and comprehensibility. The cases examined here suggest that SFBT helps parents to perceive their situation in a way that encourages a 'sense of coherence' through empowerment, integrating the goal into the mothers' life narrative and contemplating their children's abilities.

### ***The children who participated in the session***

There is evidence that if SFBT is tailored to the needs of people with mild ID they can make use of it (Franklin et al., 2001; Stoddart et al., 2001; Thompson & Littrell, 1988). The adults who completed a course of adapted SFBT in the study by Stoddart et al. (2001) had either borderline or mild ID; two with moderate ID did not complete the course. The most able child in this study initially thought to have a severe ID was found to have moderate ID; he managed to participate a little in the session. However, child Grant, whose comprehension was affected by autism and severe developmental delay had a different experience. A focus on details rather than the whole, poor understanding of the future, difficulties differentiating fantasy and realities are characteristics of autism. It is logical that he struggled with some of the SFBT components. It also raised questions about the ethics and safety of some SFBT components for individuals with social communication difficulties.

### ***Reflections for future practice and research***

On the basis of the experience with Grant, who has autism, caution is suggested when considering using SFBT with individuals who have social communication difficulties. Research needs to determine who can make use of SFBT and the adaptations needed. However, the cases do suggest that SFBT can be a useful approach for mothers and may be worth exploring with other groups of carers. The parallels with styles of problem solving, coping and shifting narratives thought to be helpful to these families are of particular interest. However, no amount of therapy is likely to take away families' needs for practical support and resources. Talking therapies remain only part of the network of support for families.

Some adaptations to SFBT are considered to tailor it to these parents' needs. The early phases of SFBT, that cover pretreatment change, coping questions and problem-free talk, seem useful to emphasize. This concurs with recommendations from the Salamanca research group (Beyebach & Carranza, 1997; Beyebach et al., 1996, 2000). Scaling exercises and visualizing a hypothetical future also seemed useful. The experience here also suggests that it is useful to validate mothers' feelings about the goal and address them with a solution-oriented stance. There is a possibility that practitioners take a completely nonexpert position and disregard parents' requests for information or cognitive assessment. Using SFBT as an initial session or sharing and integrating knowledge in the later phases of SFBT could overcome this. Beyebach et al. (1996) suggest that successful SFBT sessions are characterized by a long listening phase and a brief ending in which the practitioner speaks more. Alternatives to the miracle question seemed more effective at eliciting a description of a hypothetical future for this client group. However, an important process of loosening allegiance to 'wishful thinking' and contemplating the child's abilities appeared to occur in response to the miracle question. It is not clear whether this would occur if the question were dropped or raised in a different way. It will only become clearer as practitioners experiment with this, reflect, evaluate and share case material. Further exploration of SFBT as a means of generating a respectful, collaborative therapeutic relationship with carers is suggested.

In conclusion SFBT appears to have a potentially useful role with parents supporting a child with significant ID but there is scope for further work to tailor it to their needs

and to assess efficacy. Future research on SFBT could usefully include measures of the therapeutic alliance, self-efficacy, sense of control, positive perceptions, coping and coping styles.

### Note

1. (P = psychologist; M = mother; C = child with ID; . . . = words omitted; [ ] = clarifying information.)

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