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Solution-Focused Brief Therapy With Persons With Intellectual Disabilities

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Abstract Solution-Focused Brief Therapy (SFBT) is a short-term, goal-focused, and client-directed therapeutic approach that helps the client construct solutions rather than dwell on problems. SFBT has rarely been used with clients with intellectual disabilities (ID). The authors discuss how this relatively new form of therapy in an adapted form can be made suitable for clients with ID. The assumptions of this therapeutic approach, the types of problems and settings addressed by SFBT, and a description of the interventions used in SFBT are considered. Indications and contraindications for SFBT and empirical data on the effectiveness of the therapy are discussed both with regard to clients with or absent ID. The authors suggest that tailoring SFBT to clients with ID can be done by using simple language, modified interventions, and inserting other adaptations into the therapy process. In practice, even though clinical practice experience with SFBT has shown great promise, empirical research into SFBT applications with clients with ID is lacking. Research is thus needed to demonstrate whether SFBT with this target group can yield sufficiently effective results and to what extent SFBT is valued by clients and their carers.

Keywords: behavior therapy, intellectual disabilities, Solution-Focused Brief Therapy

INTRODUCTION

Psychological problems frequently occur in people with intellectual disabilities (ID). Compared with the general population, they are reported to experience behavior problems and/or psychiatric disorders twice as often (Cooper, Smiley, Morrison, Williamson, & Allan, 2007; Crews, Bonaventura, & Rowe, 1994; Menolascino, Levitas, & Greiner, 1986). As therapeutic interventions, various therapies have been developed to positively influence behavior, such as environment adaptation, behavior therapies, and family therapy. These are all branches of psychotherapy that can also be used for clients with ID. Recent research and clinical practice experiences have shown that clients with ID can benefit from individual, couple, family, and group psychotherapy. For example, Beail and his colleagues (Beail, 2001; Beail, Kellett, Newman, & Warden, 2007; Beail, Warden, Morsley, & Newman, 2005; Newman & Beail, 2002) posited that psychotherapy has efficacy with persons with ID and demonstrated reductions in psychological distress and interpersonal problems and increases in self-esteem, and tendencies toward lower reoffending rates. Prout and Nowak-Drabik (2003) examined 83 cases of psychotherapy involving persons with ID. Their meta-analysis pointed to a moderate degree (a mean of 3.15 on a scale of 1–5) of positive changes in outcome measures (e.g., a reduction in anger, anxiety, depression, and weight-related problems and an increase in social, relaxation, and problem-solving skills, as assessed by objective instruments) and a moderate degree (a mean of 2.72 on a scale of 1–5) of effectiveness (e.g., an increase of perceived self-esteem, autonomy, locus of control—as reported by clients).

Nevertheless, clinicians (e.g., Roeden & Bannink, 2007a; Royal College of Psychiatrists, 2004; Smith 2005, 2006; Stoddart, McDonnel, Temple, & Mustata, 2001) have recommended modifying regular therapeutic approaches when working with individuals with ID, adjusting these therapies in accord to their developmental level (through the use of simpler language and modified interventions), as well as via other adaptations (including drawings, symbols, photographs, dolls, stories, or other narrative approaches) to the therapy process. One approach used in general practice, termed Solution-Focused Brief Therapy (SFBT; de Shazer, 1985, 1988, 1991, 1994), has gained popularity over the past 20 years. SFBT represents a short-term, goal-focused, and client-directed therapeutic approach that helps clients focus on solutions rather than problems. In SFBT the client is considered an expert with regard to his or her own situation. One of the central assumptions is that the goal of the therapy is defined by the client and that he or she has the competences and resources to realize this goal. In this, the therapist is expert in asking solution-focused questions that stimulate the client to formulate his or her goal rather than suggesting or prescribing the solutions. The attitude of the therapist is one of "leading from one step behind" and "not knowing" (meaning that the therapist asks questions and does not give advice). Some therapists have started to develop and adapt SFBT for use with adults with ID (e.g., Bliss, 2005; Cooke, 2003; Lloyd & Dallos, 2006, 2008; Murphy & Davis, 2005;

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Roeden & Bannink, 2007a, 2007b; Smith, 2005, 2006; Stoddart et al., 2001; Westra & Bannink, 2006a; 2006b).

In this paper the focus is on (1) describing the adaptations of SFBT that make it useful with adults with ID; and (2) providing an overview of the application of these adaptations. Also the paper contains a description of the assumptions, types of problems, and settings addressed by SFBT, as well as the interventions, indications, and research findings of SFBT in general. With respect to the adjustments to the SFBT approach when used with clients with ID, we note what attention was paid to indications, contraindications, and empirical evidence. There is a reflection on future directions in research and practice of SFBT with clients with ID.

METHOD

A literature search was performed to examine the nature and evidence of the use of SFBT in general and with persons with ID. Relevant literature was retrieved from Medline, PsycInfo, and ERIC. Keywords in the search were "intellectual disabilities" (being the mesh-term), "SFBT," and "Solution-Focused Brief Therapy."

RESULTS

Assumptions for SFBT

SFBT is a short-term, goal-focused, and client-directed therapeutic approach that helps the client in therapy realize his or her goal by constructing solutions rather than analyzing problems. Elements of this preferred future are generally already present in the client's life and form the basis for ongoing change. SFBT is usually concluded within six sessions. SFBT therapists work with individuals and/or groups. The following are considered seven of the most important solution-focused assumptions (Selekman, 1993).

Considering the client's behavior as resistance is not useful It is important to approach each client in a cooperative manner rather than from a position of resistance, power, or control. To reach the defined goal of the client, the therapist matches the questions and therapeutic tasks with the client's unique way of reacting. The therapist further enhances the cooperation process by using the client's competences and recourses, his words and opinions.

Change is inevitable The question is not whether but when change will occur. The client is invited to make positive self-fulfilling prophecies. A direct relation appears to exist between talking about positive change and realizing this change. It is helpful to talk about successes in the past, present, and future.

Only a small change is necessary As soon as the client is encouraged to notice and value small changes, he or she will start believing that other, perhaps more important changes can also occur. Often the beginnings of a solution already lie in the client but remain unnoticed. These are illustrations of the exceptions to the problem (hidden successes) and give insight into which positive actions could be enacted to a greater extent or more often.

Clients have the strengths and resources to change Everyone has strengths and resources. Any past successes of the client can serve as models for present and future successes.

You do not need to know a great deal about the problem to solve it SFBT assumes that no problem is always present to the same extent. The solution-focused therapist will not explore and analyze the cause or details of the problem but will look at what the client is doing differently when the problem is not there or there to a lesser extent.

The client defines the goal of the therapy Treatment is based on the goal of the client, not on that of the therapist. The client is invited to create a detailed picture of what his or her life will be like once his or her goal is reached. Ideally, the client's description will contain the "who," "what," "where," "when," and "how" of goal attainment.

There are many ways of looking at a situation; one is no more "correct" than another There are no definitive explanations or descriptions of reality. Solution-focused therapists are not attached to their own theories but rather focus on the client's theory of change.

Types of Problems and Settings Addressed by SFBT

SFBT is increasingly used for helping clients with a wide range of problems including alcohol abuse (Berg & Miller, 1992), sexual abuse (Dolan, 1991), eating disorders (Jacob-Doreleijers, 2001), posttraumatic stress disorder (Bannink, 2008a; Berg & Dolan, 2001; Dolan, 1991; O'Hanlon & Bertolino, 1998), depression (Berg & Steiner, 2003; Cladder, Nijhof-Huysse, & Mulder, 2000; O'Hanlon & Bertolino, 1998), personality disorders, and psychoses (Bakker & Bannink, 2008; Bannink, 2008; O'Hanlon & Rowan, 2003). In addition, SFBT is used with children and adolescents (Bannink, 2006b; Berg & Steiner, 2003; Metcalf, 1995; Selekman, 1993, 1997) as well as with groups (Furman, 2007; Metcalf, 1998). The solution-focused model is also effective in management and coaching (Cauffman, 2003), in education (Franklin, Biever, Moore, Clemons, & Scamardo, 2001; Goei & Bannink, 2005), in organizations (Stam & Bannink, 2008), and in mediation (Bannink, 2006a, 2008a, 2008b). Most recently SFBT has been used with people with ID (Bliss, 2005; Cooke, 2003; Lloyd & Dallos, 2006, 2008; Murphy & Davis, 2005; Roeden & Bannink, 2007a, 2007b; Smith, 2005, 2006; Stoddart et al., 2001; Teall, 2000; Westra & Bannink, 2006a, 2006b).

SFBT in Practice

As part of the six-session process, generally a solution-focused conversation contains certain specific elements. The first element is the *opening question*. Through the therapist's opening question (e.g., what brings you here?) the client may describe his or her problem, or he or she may immediately indicate the goal of the therapy. The second element is *pre-session changes*. As most clients have tried other possibilities before connecting with a therapist, the practitioner can ask whether and what changes have already

occurred before the first session. The third element is *goal setting,* where a clearly formulated goal is developed and the client is invited to describe what will be different in his or her life once his or her goal is reached. This could be done by means of the "miracle question"—"*imagine a miracle occurring tonight that would (sufficiently) solve the problem . . . what would be different tomorrow?*" The therapist may also suggest that changes are possible (e.g., "*When you look forward and things have improved, what will you be doing differently? How will other people know that things have improved?*"). The therapist may also indicate with the question "*What else?*" that there is more to come. Clients often respond to this simple query by giving more information and ideas.

Exploring the exceptions The therapist asks questions regarding the moments in the client's life when the problem does not occur or is less serious and who does what to bring about these exceptions. The therapist may also ask questions relating to moments that have already met (to a degree) the goal of the client and how the client facilitates these moments taking place.

Scaling questions In order to measure progress during therapy and to measure and stimulate hope, motivation, and confidence that the goal can be reached, scaling questions (10 = "very good," 0 = "very bad") are used. They help the client to move away from all-or-nothing goals toward manageable and measurable steps.

Competence questions The therapist uses competence questions whenever possible, which are indirect compliments (e.g., "*How did you know that was the right thing to do?*") to stimulate the client to figure out the resources used to achieve success.

Assessing the client–therapist relationship During the session the relationship (visitor, complainant, or customer) with the client is assessed. In a visitor-relationship the client is mandated or referred by others. He does not voluntarily seek help and is not suffering emotionally. In a complainant-relationship the client does have a problem and is suffering emotionally, but he or she does not (yet) see himself or herself as part of the problem and/or the solutions. Another person (or something) needs to change rather than himself. In a customer-relationship the client does see himself or herself as part of the problem and/or solutions and is motivated to change his or her behavior. In the visitor-relationship the therapist may ask what, according to the client, the person referring him or her would like to see changed in his or her behavior and to what extent the client is prepared to cooperate. In the complainant-relationship the therapist acknowledges the client's suffering and gives suggestions for observing the moments when the problem is or was there to a lesser extent. In the customer-relationship the therapist relates to the existing motivation and stimulates change by giving the client suggestions for behavior corresponding with the goal (e.g. "*if it works, continue with it*," "*if it does not work, do something different*," or "*act as if the miracle has already happened*").

Feedback At the end of every session feedback with compliments and usually some homework suggestions are given. The compliments emphasize what the client is already constructively doing to reach his or her goal. The suggestions indicate areas requiring the client's attention or possible further actions to reach his or her goal. The therapist may also ask the client for feedback. (e.g., by using the Session Rating Scale developed by Duncan, Miller, & Sparks, 2004).

Indications for SFBT SFBT applications are suitable if (1) the client has a goal before treatment or is able to formulate one during therapy; (2) the client is able to communicate (if not, SFBT can still be used with the carers of the client); and (3) the therapist does not see himself or herself as the expert and does not advise the client.

Empirical Evidence From the Use of SFBT

In their overview of 15 case studies of SFBT therapy, Gingerich and Eisengart (2000) distinguished between methodologically well-monitored and less well-monitored research. Five well-controlled studies revealed successful outcomes (i.e., reduction of depression, improvement of parenting skills, improvement of psychosocial adjustment after injury, decrease of recidivism of prisoners, and decrease of antisocial behavior). Four moderately controlled SFBT studies demonstrated that better outcomes were achieved compared with no treatment or standard institutional services (i.e., increase of students' goal achievement, improvement of counseling skills with school-age children, reduction of oppositional behavior in children, and improvement of marital satisfaction). Despite the methodological limitations of the remaining six studies, they showed positive outcomes.

Stams, Dekovic, Buist, and de Vries (2006) carried out a meta-analysis of 21 SFBT studies, including some 1,421 clients, to achieve quantitative evidence for the efficacy of SFBT. The average effect size (Cohen's d) for the influence of SFBT was 0.37 (95% confidence interval: 0.19–0.55), indicating a slight positive effect on the reduction of problems. The effectiveness of SFBT proved to be greater with clients treated in residential settings ($d = 0.60$) than for clients in nonresidential settings (families, $d = 0.40$; schools, $d = 0.23$). Also, SFBT proved to be more effective with clients with behavior problems ($d = 0.61$) than for clients with marital ($d = 0.55$) or psychiatric problems ($d = 0.49$).

Adaptations of SFBT for Use With Individuals With ID

SFBT has a number of advantages that make it attractive for use with clients with ID, including (1) a focus on skills rather than deficits; (2) a unique intervention for each client based upon his or her particular skills and needs; (3) an expert status for the client and hence a sense of self-efficacy within the therapeutic relationship; (4) a focus on empowerment, thus on competences and resources; and (5) a perceived effectiveness for clients in residential settings.

Several authors have suggested adjustments to SFBT from those originally described by de Shazer (1985, 1988, 1991, 1994) because of the specific needs, developmental levels, and abilities of individuals with ID (Corcoran, 2002; Lentham, 2002; Murphy & Davis, 2005; Roeden & Bannink, 2007b; Smith, 2005, 2006; Stoddart et al., 2001; Teall, 2000; Westra & Bannink, 2006a, 2006b). Specifically they have recommended a greater use of

TABLE 1
Shortened solution-focused questions

Interventions	Key questions
Acquaintance	Who are you? What do you like? What are you good at? What are you proud of?
Pre-session change	What has already changed since . . . ? What is better since . . . ?
Goal seeking	What do you do instead (of the problem)? What are you hoping for? What difference would that make? What else?
Exceptions	When is/was it[a] less serious? When is/was it[a] better? What do/did you do differently? What did you try? What was helpful? What else?
Scaling	When 10 is . . .[b], When 0 is . . .[b], Where are you now? How did you do that? What is your next step? What is your next sign of progress? How can you get there?
Competences	How do/did you do that? How did you succeed? How do/did you manage? How are/were you able to . . . ?

[a]It is the problem as described by the client.
[b]Preferably: one word.

simple language, a flexible approach to questioning, alterations to engagement and in exploring exceptions, and adaptations in goal setting and scaling.

The use of simple language. Workers have recommended that sentences should be short, clear, and simply constructed. Table 1 summarizes some of the main solution-focused questions using only three, four, or five words. They have also recommended that the therapist use the terminology of the client as much as possible and monitor whether the client has understood the message.

Flexibility in questioning. Recommendations have evolved that the client with ID be offered sufficient time to answer questions and develop ideas and be encouraged to reflect during and between therapy sessions. The concentration span of the client will influence the duration of the session. Some clients may require sessions longer than an hour, while others may be limited to half an hour. In addition, the sequence of the questions may vary so as to obtain useful responses for further exploration. The therapist can only use those aspects of the solution-focused repertoire that the client understands and finds useful and that make a difference. Because of this, the repertoire may have to be reduced for clients with ID.

Engagement. There is common recognition that mutual engagement between the client and the therapist is of great importance. This begins with the therapist making small talk with the client; the therapist may, for example, inquire into the client's work, study, hobbies, interests, and musical taste. When the client is referred by others for behavior problems (a common occurrence), he or she is usually engaged in a visitor-relationship. In this context, adaptations of engagement strategies are even more important in facilitating the development of a cooperative spirit between client and therapist.

Adaptations in exploring the exceptions. Many clients with ID may experience cognitive difficulties in exploring the past to retrieve exceptions. Therefore, the workers have recommended the use of partly nonverbal techniques such as topographic analyses, video exceptions, drawing, and role-play, which can help bring past exceptions into concrete and present focus. Topographic analysis describes specific behavior at a specific time and place, and the focus is on the exceptions—that is, when did undesired behavior not occur or occur to a lesser extent? This context can be described by the client as well as drawn from important helpers (such as family members or other carers). Recording video exceptions (Murphy & Davis, 2005) is another useful technique in which day-to-day situations in the client's life are filmed. The video matter is edited to include only instances of successful and desired behavior (which are "the exceptions"). Once an exception is discovered, the film is shown to the client and relevant contextual details can be explored using solution-focused questions. On viewing his own successful behavior, the client is stimulated to increase such behavior (self-modeling). Also, the use of drawing and role-play (Corcoran, 2002) can make successful strategies concrete. For example, the client may draw and/or role-play a successful morning ritual (e.g., brushing teeth, getting dressed, eating breakfast), showing his ability to get ready effectively in the morning (and thus, for example, showing exceptions to the undesired behavior of lingering).

Adaptations in goal setting. Many workers have noted that the "miracle question" may often be too complicated for the client with ID. Therapists applying SFBT should try to shorten or change this question. Some examples of alternative questions are "*What will it be like when the problem is solved?*" "*What will you be doing instead tomorrow morning?*" "*How do you describe yourself on a really good day?*" "*What is your best hope?*" "*What will be different then?*" "*What are you wishing for?*" Table 2 provides a case example of the dialogue between a therapist and a client.

Adaptations in scaling questions. Stoddart et al. (2001) are credited with modifying the scaling technique from a 10-point to an easier 3-point scale. However, other options have also been presented for scaling, including the use of visual aids, emoticons, ladder rungs, a thermometer, stepping stones, or circles divided into sections (indicating happy or sad) (Lentham, 2002; Roeden & Bannink, 2007a).

Involvement of the client's social environment. The involvement of others (carers, family) in the therapy process plays an important role for clients with ID. The use of other professional and family support in therapy is needed not only to encourage and explain homework assignments (to be carried out between sessions) but also to define topics to be addressed (Stoddart et al., 2001; Teall, 2000). However, well-meaning, overinvolved carers should be invited to adopt an attitude of "leading from one step behind" (Smith, 2005, 2006).

TABLE 2
Solution-focused case

Ann has been feeling depressed for weeks. The day before the session she did little else but dejectedly lie on the couch. To develop a clearly formulated goal she is asked about her preferred future. Part of the dialogue is as follows:
Therapist (T): "How would you describe yourself on a really good day?"
Ann (A): "I would be cheerful and active."
T: "How could I see that you are cheerful and active?"
A: "Then I laugh more often, I am more active."
T: "How could I notice that you are more active?"
A: "Then I would make cards to send to people" (shows handmade cards).
T: "Well, they are real works of art! What else do you do when things are going better?"
A: "Then I will have tidied up my room better and made a meal for myself again."
T: "That is excellent! How will you achieve this?"
A: "I will do that together with my coach."
T: "How will you go about that?"
A: "Step by step."
T: "What could be the first small step? What are you thinking of?"
A: "I won't just be sitting on the couch watching TV anymore."
T: "How will you get back into the swing of things?"
A: "I would try to get some fresh air before doing necessary things."
T: "Good idea. How would you do that?"
A: "I will walk my dog Winny again."
T: "So you must be feeling responsible?"
A: "Yes, that will make Winny very happy."
T: "How would you notice that in Winny?"
A: "Ooh then she will jump up at me. She is always cheerful, also when I am grumpy."
T: "How does that help you?"
A: "Uh . . . she helps me get through it."
T: "Well, then you have chosen a good housemate. What else helps?"

Adaptations in homework assignments. Because some individuals with ID often cannot remember assignments (especially those of a cognitive nature), the use of prompts and/or written or visual aids provided by carers may help. To prevent the client from becoming overwhelmed, assignments should be simple, realistic, and few in numbers. The task can be given to both the client and his or her carers. It may also be given as an experiment; thus, the pressure to be successful is reduced.

Indications and contraindications for SFBT with clients with ID SFBT seems to be the most successful for clients with mild ID rather than moderate to profound ID; clients who are self-referred; clients who are supported in the therapeutic process by others; clients with behavior problems; and teams of carers (Roeden & Bannink, 2007a; Stoddart et al., 2001; Westra & Bannink, 2006b). SFBT seems to be less useful for clients with autism because of their poor understanding of the future and difficulty in differentiating between fantasy and reality (Lloyd & Dallos, 2006).

Empirical evidence on SFBT with clients with ID The research literature on the use of SFBT with clients with ID is scarce and suffers from methodological limitations such as small sample sizes, lack of statistical power, poorly controlled studies, and vague or omitted outcome data. Stoddart et al. (2001) reviewed outcomes of 16 clients with mild to borderline ID receiving SFBT in which clinicians rated the degree to which the outcome was successful on a five-point Likert scale (1 = "unsuccessful" to 5 = "very successful"). Data were ascertained from client records. Using this method, problems relating to poor self-esteem, family relationships, and bereavement were most successfully treated in SFBT (success ratings 3.7–5.0), whereas depression and anxiety, couple conflict, and independence issues were the least successfully improved (success rating 2.0–3.3). However, these success ratings were not compared with controls.

Client satisfaction and length of SFBT were compared with clients receiving traditional psychotherapy. SFBT took significantly less time than traditional therapy (a mean length of 118 days vs. 372 days registered in service; $p < 0.001$), with shorter waiting times until the beginning of the therapy (a mean length of 230 days as opposed to 312 days for regular therapy; $p < 0.05$). According to six-month follow-up questionnaires regarding SFBT, clients and their carers were equally satisfied with the services when compared with traditional psychotherapy.

Murphy and Davis (2005) used a solution-focused intervention (video exceptions, see previous section) with a 9-year-old boy with moderate ID. This client displayed no vocal communication, and his expressive language was limited to about 12 highly functional "single signs" from American Sign Language. Before treatment, the client's use of sign language to express his needs had dropped to unacceptable levels (he would resort to pointing, grunting, hitting, or yelling). The mean percentage of 10-second intervals in which the client signed (preferred behavior) during 10-minute observation periods increased from 23% at baseline to 71% during intervention. Follow-up observations 1 month after the intervention revealed that the client's signing still was markedly improved, namely in 64% of the intervals measured. No statistical information was given in this case study.

Roeden and Bannink (2007b) described how a solution-focused and a traditional behavior therapy were combined to treat a 21-year-old woman with a dysthymic disorder and borderline ID. The goal of the treatment (as formulated on basis of the miracle question) was to be happy and active. The exploration of exceptions gave clues about the client's competences and strategies for success. Depressive symptoms were measured before and after treatment using validated instruments developed for use with clients with ID (depression interview—Roeden, Helbig, & Zitman, 1995—and the mood scale of the temperament questionnaire—Blok, van den Berg, & Feij, 1990). By the end of the treatment, the progress made by the client meant that she no longer met the criteria for having a dysthymic disorder.

With regard to socioeconomic groups, Macdonald (2007) found no significant differences in the effects of SFBT. This is an important finding as all other psychotherapies are more effective for clients from higher socioeconomic groups (Meyers & Auld, 2006). This has particular relevance as individuals with ID often belong to the lower socioeconomic segments of the community.

FUTURE RESEARCH AND PRACTICE IN SFBT

Psychotherapy is useful with persons in the general population and with persons with ID. However, adaptations (such as drawings, symbols, photographs, role-plays, and narrative approaches) are necessary for the latter group. Beail (2003) reviewed several studies on cognitive behavioral and psychodynamic psychotherapy research and noted several (methodological) shortcomings in these studies. Beail noted that "placing people in no treatment conditions without statistical power to detect differences is poor and unethical." He also stated that getting informed consent from persons with ID may be difficult, "especially when random allocation is involved," and that study groups seemed to be rather heterogeneous. Studies also tend to be performed in clinical practice, and thus are practice based instead of evidence based. Regarding Beail's comments, it indeed may be difficult to get consent from clients with ID because they may not understand the full impact of the therapy. For SFBT, however, usually consent is obtained easily as the client defines his or her own goal for treatment and the course of action.

SFBT, in an adapted form, may be a promising therapeutic approach that focuses on what clients with ID want to have instead of their psychological problems (their preferred future). However, thorough research examining the effectiveness of SFBT ID applications with adults with ID has not been carried out. Future research with sufficient statistical power and controls should emphasize elements from evidence-based and practice-based research. In the first, the emphasis lies on the question "What works in SFBT?" Such research into the effect of SFBT on clients with ID can be carried out on an individual and a group level, as well as with staff working with clients with ID. Practice-based research primarily revolves around the question "What works for this specific client, in this specific situation, at this moment?" To address the efficacy of SFBT approaches, research should include questions focusing on the effect of SFBT on clients with ID, on the opinions of clients with ID and of professionals about SFBT, and on the therapeutic cooperation.

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