Journal of **Policy and Practice in Intellectual Disabilities**

Journal of Policy and Practice in Intellectual Disabilities
Volume 8 Number 4 pp 247–255 December 2011

Solution-Focused Brief Therapy With People With Mild Intellectual Disabilities: A Case Series

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Abstract Solution-focused brief therapy (SFBT) is a form of behavior therapy that focuses on evoking desired behavior rather than on the existing problem behavior. To illustrate the use of this form of therapy, the authors undertook a study of 10 case studies of applications of SFBT with people with a mild intellectual disability (MID). For all 10 cases, before SFBT, after SFBT, and during a follow-up after 6 weeks, the following measurements were taken: assessment of quality of life and assessment of maladaptive behavior as well as goal attainment according to people with MID and according to carers. It was found that SFBT treatments contributed to improvements in psychological functioning and decreases in maladaptive behavior. In addition, achievement of goal attainments were noted according to both people with MID and their carers. The positive changes evident after SFBT proved sustainable during follow-up. Treatment strategies and therapeutic alliances employed were usually assessed as positive by the participants. Although the study had limitations due to the lack of a control group and the small number of cases, the fact that several case studies showed positive treatments results did indicate the effectiveness of SFBT for people with MID.

Keywords: behavior therapy, challenging behavior, intellectual disabilities, solution-focused brief therapy

INTRODUCTION

Psychological problems frequently occur in people with intellectual disability (ID). Compared with other people, adults with ID are reported to experience many more behavior problems or psychiatric disorders (Cooper, Smiley, Morrison, Williamson, & Allan, 2007; Crews, Bonaventura, & Rowe, 1994; Didden, Collin, & Curfs, 2009; Menolascino, Levitas, & Greiner, 1986). Various therapies have been developed to positively influence behavior such as environmental adaptations, behavior therapies, and family therapy (Beail, 2001; Beail, Kellett, Newman, & Warden, 2007; Beail, Warden, Morsley, & Newman, 2005; Newman & Beail, 2002). Solution-focused brief therapy (SFBT; De Shazer, 1985) is a behaviorally orientated treatment that has gained popularity over the past 25 years. SFBT represents a short-term, goal-focused, and client-directed therapeutic approach that helps the client focus on solutions rather than problems.

The aim of this study was to illustrate the efficacy of applications, processes, and effectiveness of SFBT in people with mild ID (MID). To proceed, we first explain the assumptions and processes of SFBT and its use for people with ID. Thereafter, we consider the processes and applications of SFBT with people with MID and then describe the results and conclusions.

Received December 29, 2010; accepted July 27, 2011
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SFBT: Assumptions and Processes

One of the central assumptions of SFBT is that the goal of the therapy is defined by the client and that the client has the competencies and resources to realize this goal. During this process, the client is invited to describe what will be different in the future once his or her goal has been reached and to explore *exceptions* to the problems (times when problem behavior does not occur). The therapist stimulates the client to describe progression toward the therapy goal in specific, small, behavioral steps. The therapist also suggests tasks such as "continue with what is working already" in order to stimulate or maintain changes. At the start, variations in the relationship with the client (i.e., whether it is *visitor, complainant,* or *customer relationship*) are assessed and identified. In a *visitor relationship*, the client is referred to the therapist by others. In this relationship, the client does not voluntarily seek help and is not experiencing emotional difficulties. In a *complainant relationship*, the client does have a problem and experiences emotional difficulties, but he or she does not (yet) see himself or herself as part of the problem and/or the solution. In a *customer relationship*, the client does see himself or herself as part of the problem and/or solution and is motivated to change his or her behavior. Each type of relationship requires different approaches by the solution-focused therapist toward the client. For example, in the visitor relationship, the therapist may ask what the referrer would like to be different in the future and to what extent the client is prepared (at a minimum or maximum) to cooperate in the process. In the complainant relationship, the therapist

acknowledges the client's difficulties and gives suggestions for observing the moments when the problem is or was there to a lesser extent. In the customer relationship, the client may be given a behavior assignment (e.g., "continue with what is working already").

SFBT: Use With People With ID

SFBT has a number of advantages that makes it attractive for use with people with ID. These include: focus on empowerment and on skills rather than on deficits, unique interventions for each person based on particular skills and needs, and recognition of the expert status of the individual resulting in a sense of self-efficacy within the therapeutic relationship (Roeden, Maaskant, & Curfs, 2011). SFBT regards the client as expert, and thus is in line with the present view on ID that focuses on empowerment and competencies of people with ID (Gallant, Beaulieu, & Carnevalle, 2002; Martin, 2006). Several authors have suggested adjustments to SFBT as it was originally described by De Shazer (1985) for people with ID, due to their specific needs, developmental, emotional, and cognitive levels and abilities (Corcoran, 2002; Lentham, 2002; Murphy & Davis, 2005; Roeden & Bannink, 2007a, 2007b; Roeden, Bannink, Maaskant, & Curfs, 2009; Smith, 2005, 2006; Stoddart, McDonnel, Temple, & Mustata, 2001; Teall, 2000; Westra & Bannink, 2006a, 2006b).

These recommendations include the use of simple language, flexibility in questioning, and allowing the person with ID enough time to answer questions, develop ideas, and reflect on what is transpiring during sessions. Also, it is advantageous to use visual aids, such as emoticons and drawings, to involve carers and family, to encourage and explain tasks, and to adapt task assignments (such as the use of prompts and written or visual aids). In application to the general population, SFBT has been the subject of an increasing number of outcome studies (cf. Bannink, 2010; MacDonald, 2007). Stams, Dekovic, Buist, and de Vries (2006) conducted a meta-analysis of SFBT in which they compared 21 studies and noted a modest positive effect of SFBT in a short time (an average of six SFBT sessions). However, research literature on the use of SFBT among people with ID is scarce, but that which is available has been shown to have some promising positive treatment effects. Stoddart et al. (2001), for example, reviewed 16 people with mild to borderline ID receiving SFBT. Clinicians rated the degree to which the outcomes, as ascertained from client records, were successful on a five-point Likert-style scale (1 = unsuccessful to 5 = very successful). Using this method, problems relating to poor self-esteem, family relationships, and bereavement were most successfully treated with SFBT (success ratings 3.7–5.0), whereas depression and anxiety, couple conflict, and independence issues showed the least improvement (success rating 2.0–3.3).

Because more information was needed as to the usefulness of applications of SFBT with adults with MID, we conducted an exploratory study of SFBT procedures with 10 people who had experienced adjustment difficulties. We expected that SFBT could assist them in improving their quality of life, in reducing maladaptive behaviors, and in attaining their treatment goals. In addition, we expected that participants in this study would appreciate the SFBT experience. As part of our study, we first described the treatment protocol. Second, we collected data by measuring differences before SFBT, directly after SFBT, and 6 weeks after SFBT, with regard to three variables or outcomes. These were quality of life, maladaptive behavior, and goal-attainment perceptions according to both adults with MID and their staff carers. Third, to get at the experiential variables, we collected opinions about the SFBT procedure and the collaborations from our 10 subjects.

METHODOLOGY

The study was conducted at the program sites of a service provider for children and adults with ID (serving approximately 900 people) in the Netherlands. People enrolled with this provider use various residential services such as day care and home care. This service provider employs, among others, qualified psychological therapists, and one of the services offered is SFBT.

Participants and Procedure

Participants Ten of the provider's clients were nominated to participate in the study as they all had some "issue" that warranted change, and it was thought that SFBT would be the means to make those changes. The 10 participants (labeled C_1–C_{10} in the tables) lived semi-independently and received individual support (ranging from 2 to 14 h per week) from staff carers employed by the service provider mentioned previously. The support they received included help with housekeeping tasks (such as cleaning and cooking), with financial tasks (such as banking), and with social-emotional tasks (such as dealing with other people and conflict management). All participants (three men and seven women with a mean age of 39 years) in the study had MID determined on the basis of intelligence quotient (tested by means of the WISC-III-NL (Wechsler, 2005a) or the WAIS-III-NL (Wechsler, 2005b)) and adaptive functioning (tested by means of the SRZ-plus—a Dutch adaptive behavior scale—Kraijer & Kema, 1994). None of the participants had acute psychiatric conditions. All participants had been referred for SFBT by their staff carers.

All of the participants agreed to participate in the study and provided permission for anonymous publication of the study data. Permission for the research study was given by the client council (made up of clients with ID) and by the organization's client representative council (family members or other representatives of people with ID). Both councils acknowledged that the research proposal corresponded to guidelines for carrying out research projects involving people with ID in the Netherlands.

Procedure The study was composed of 10 SFBT applications with five sessions each. The sessions and treatment protocol are described in Table 1. The average duration of the five SFBT sessions was 12 weeks. Every SFBT session was attended by at least three people: the person with MID, the staff carer, and the therapist. In our application of SFBT, we decided that every person with MID would be accompanied by a carer. This was because it appeared from the treatment practice of SFBT that the interventions are better understood and executed when carers perform a

TABLE 1
SFBT treatment protocol with sessions, interventions, and descriptions

Session	Intervention	Description
Intake	Getting acquainted	The therapist spends time to get to know the client. Competencies and resources are being explored.
	Exploring the problem	The therapist invites the client to describe his or her problem and/or to mention his or her goal for the treatment.
First session	Pre-session change	As most clients have tried other possibilities before connecting with a therapist, the therapist can ask whether what changes have already occurred before the first session.
	Goal setting	The client is invited to describe what would be different 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?").
	Exploring the exceptions	The therapist inquires about moments in the past or present when the problem did not or does not occur or is less serious and who does what to bring about these exceptions.
	Scaling questions	On a scale of 10 to 1, the client indicates his or her progression toward the goal. Scaling questions help the client to move away from all-or-nothing goals toward manageable and measurable steps.
	Competence questions	By using competence questions, self-compliments are being provoked with the client. "How do (did) you do that?" Direct compliments are aimed at something the client has done, made, or said.
	The question: "what else?"	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.
	Feedback	At the end of every session, feedback with compliments and usually some homework are given. The compliments emphasize what the client is already 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. Between the components *compliments* and *suggestions/tasks* a *reason* (or *bridge*) is given to perform those tasks.
Follow-up sessions	The question: "What is better?"	The standard beginning question is: "What is better?"
	EARS = Eliciting, Amplifying, Reinforcing, and Start again	Eliciting, amplifying, and reinforcing of (small) successes, exceptions to problems, or descriptions of the desired future and the invitation to the client to do that again or more often.
	Feedback	Compliments—bridge—tasks

SFBT, solution-focused brief therapy.

supportive role in the treatment procedure (Roeden & Bannink, 2007a; Stoddart et al., 2001; Teall, 2000). The following problems were reported by the 10 participants and their staff carers: alcohol abuse (three adults), anger (two adults), bereavement (one adult), depression/apathy (one adult), sleeplessness (one adult), low self-esteem (one adult), and avoidance/anxiety (one adult). In each application, three data measurements were taken: the first immediately before SFBT, the second immediately after ending SFBT, and the third during a follow-up measurement 6 weeks after SFBT. The measures provided objective information about the treatment effects derived from standardized measuring instruments and assessment information on the clients' and carers' opinions about treatment effects and treatment processes. To be able to determine whether differences existed at individual level between the before, after, and follow-up measurements, the criteria for statistically significant and/or clinically relevant differences for each measure were determined *a priori*.

Statistical analysis Because of the relatively small sample size (10 clients), a nonparametric test (Wilcoxon signed-rank test) was used to analyze the data, rather than a parametric test. The Wilcoxon signed-rank test, a nonparametric statistical hypothesis test for repeated measurements, was performed on four variables: quality of life, psychological functioning, social functioning

(using the the Intellectual Disability Quality of Life (IDQOL-16), see Measures section), and goal attainment (using the Scaling Question Progression (SQP), see Measures section). In order to control the problem of multiple comparisons, the Dunn–Bonferroni correction (Dunn, 1961) was used by dividing the *p*-value by the number of variables: $\alpha/n = 0.05/4 = 0.0125$ (round 0.01).

Treatment protocol The treatment protocol consisted of seven meetings: an intake, five solution-focused sessions, and a follow-up. Every treatment followed the protocol as summarized in Table 1. During the intake, the strengths as well as the problems of the person with MID were assessed. At intake, the therapist asked about work, study, hobbies, interests, skills, talents, and significant people in the life of the adult. This information was used in the treatment sessions. The therapist did not ask questions about the details of the problem (because SFBT does not primarily focus on analyzing problems). In the first session, the therapist asked solution-focused questions, as well as queries about the goals of the person with MID, questions about exceptions to problem behavior, and questions about scaling and competence. Every first (and subsequent) session was ended by giving feedback to the person with MID and to the staff carer.

In the second and subsequent sessions, the therapist started with the "EARS-question" set. EARS is an acronym for Eliciting, Amplifying, Reinforcing, and Start again and outlines the therapeutic process. The first question was: "What is better?" The individual could respond to that question in four different ways: "It is better," "There is no change," "It is worse," or "There is a difference in opinion" (in this case between the opinions of the person with MID and the staff carer). If the situation was better, the therapist could react to that by amplifying, "What exactly is (somewhat) better?" by reinforcing, "How did you manage to do that?" and by starting again, "What (else) is better?"—EARS could also be used if the person thought there was no change. The therapist then acknowledged the client's possible disappointment and stressed the point that keeping things stable was also a good accomplishment. Then, the therapist requested the individual to explain how he or she did that. If the situation was worsening and the person with MID was disappointed, the therapist also acknowledged this. A reorientation to the goal might be necessary or the therapist could ask the person how he or she managed to keep going under difficult circumstances. That offered a possible reentry to the EARS set of questions. If there were differences in opinions between the person with MID and the carer about the amount of progress, the therapist firstly normalized this situation by suggesting that progress usually happens in steps and by trial and error. Subsequently, small improvements could be explored through EARS. An illustration of a solution-focused consultation is presented in an elaboration of a case description in Table 2.

Measures

Quality of life IDQOL-16 (Hoekman, Douma, Kersten, Schuurman, & Koopman, 2001) was used to measure the quality of life of the person being examined. The IDQOL-16 has three subscales: *psychological functioning*, *social functioning*, and *satisfaction about housing.* The IDQOL-16 has proved to have a good internal consistency (Cronbrach's α of the various subscales between 0.73 and 0.80). Every question had five response categories ranging from *very pleasant* to *very unpleasant*, made clear by a pictogram (smiley). Raw scores of the subscales were transformed into quartile scores (rating of 1–4; higher quartiles are indicative of higher satisfaction). For the total scores (1–10), high deciles were indicative of higher satisfaction. In this study, an improvement was defined as an increase of one quartile (= 25% improvement) in the subscales of psychological and social functioning, and an increase of 2 deciles (= 20% improvement) of the total score (= quality of life). The subscale of satisfaction about housing was not included in the treatment results because housing satisfaction is not a primary goal of SFBT.

Maladaptive behavior The Reiss Screen for Maladaptive Behavior (RSMB; Reiss, van Minnen, & Hoogduin, 1994) was used to measure maladaptive behavior. The RSMB measures the presence of psychological problems. The RSMB was completed by a staff carer who had knowledge of the person being evaluated. The list of questions comprised nine subdivisions: aggression, autism, psychosis, depression (behavior symptoms), depression (vital symptoms), paranoia, dependent personality disorder, avoidant disorder, and "other maladaptive behavior." The internal consistency of the nine subdivisions ranged from reasonable to good (Cronbach's α: between 0.69 and 0.87). The stability was only calculated for the total score and was good (Pearson's *r*: 0.81). The inter-rater reliability for the subdivisions ranged from reasonable to good (Pearson's *r*: between 0.50 and 0.84). For each item, the staff carer evaluated behavior items as to whether it was "no problem" (0 points), to be "a problem" (1 point), or to be a "big problem" (2 points) for each person. For each subdivision, the RSMB gave cutoff scores, indicative of the presence of psychopathology in people with MID. In this study, improvement of maladaptive behavior was defined as a change in one or more scores in a subdivision from above the cutoff score to below the cutoff score.

Goal attainment according to people with MID SQP uses a scale of 10 (*goal reached*) to 1 (*goal not reached*) on which the individual indicates to what extent he or she has approached or has reached the therapeutic treatment goal (Bannink, 2010). In a study by Fischer (2009), the scale question was used with 3,920 clients to measure *emotional coping* and *daily functioning* before and after SFBT. Differences between before and after SFBT varied between +0.9 and +2.1 points for daily functioning and between +0.6 and +1.4 point for emotional coping. In this study, a progression of +2 points (being relatively high) was regarded as clinically relevant.

Goal attainment according to carers Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968; Kiresuk, Smith, & Cardillo, 1994; Schlosser, 2004) is a technique used to evaluate an individual's progression toward a goal. For each goal, a five-point scale ranging from −2 to +2 was established. No differences in goal attainment were scored as 0. A positive change toward the goal was scored as +1 and a negative change was scored at −1. Reaching the goal was scored as +2 and a severe regression from the start situation by −2. In addition, an indicator was chosen. The indicators were measures of the effect of the intervention in the direction of the goal (e.g., "number of glasses beer per day"). To obtain a GAS, all scores were added and transformed into a

TABLE 2
An example case description of the use of SFBT

SFBT treatment protocol Intervention	**Session particulars Description**
Getting acquainted	Mr. E. (a 44-year-old man) mentioned that his interests were listening to music and making music (karaoke), gardening, and doing odd jobs. Mr. E. liked to visit people. The carer added that Mr. E. did not mind change, that Mr. E. was precise, helpful, and social, and that Mr. E. had overcome difficult problems in the past. In SFBT terminology, the therapist and Mr. E. had a client-typical relationship.
Exploring the problem	The problem with Mr. E. was lack of confidence, which was revealed by frequently asking for confirmation, pondering about his own functioning, and a tendency toward perfectionism. Even though incidental excessive alcohol use resulted in temporary relaxation, it also caused a distressing long-term feeling of guilt afterward.
Pre-session change	Mr. E. had already informed a number of bar owners and a family member that he wanted to drink alcohol responsibly.
Goal setting	The therapist asked: "Suppose we make a video that shows you are doing well. . . what kinds of things would we see and hear on that video?" Mr. E. said: "Then I would have self-confidence," and "Then my head is not so full of 'red' [worrisome] thoughts." In exchange for the problem, Mr. E. wanted to have " 'green' [light] thoughts" and drink alcohol-free beer more often instead of beer with alcohol. Green and red were the words that Mr. E. came up with himself to describe his thoughts.
Exploring the exceptions	Mr. E. said, "When I am occupied then I feel better." Mr. E. suggested that carers could assist him in planning a difficult day off. This meant that a well-filled day program during days off or on weekends would keep him from drinking too much alcohol.
Scaling question	The therapist asked, "Suppose 10 means you have self-confidence and 1 means you don't have self-confidence, what mark do you give yourself at this moment?" Mr. E. indicated he was at a 4. After asking what that 4 included and what could be done to reach a 5, Mr. E. and his carer came up with many ideas while answering these scaling questions: They could practice with chit chat (green thoughts), difficult days could be prepared together, Mr. E. could spend his free time volunteering at the local petting zoo, Mr. E. could tell bar owners that he wanted to drink less alcohol and preferred to drink alcohol-free beer instead, and Mr. E. could practice in steps ordering alcohol-free beer at a bar. Moreover, they could install a token system for alcoholic beer drinking on the weekend (one token = one beer, a maximum of three beers per evening). Planning this way, successes could be rewarded with short outings (go somewhere to have coffee). In case of continued success, Mr. E. wanted to reward himself with the purchase of karaoke equipment.
Feedback	Mr. E. viewed himself as part of the problem and the solution (a client-typical relationship). The therapist gave Mr. E. compliments about his resourcefulness (many ideas for improvement) and formulated a reason/bridge ("you have already started to deal with your problem"). The therapist suggested a task, building on the ideas from Mr. E. and his carer. The behavioral task was: "continue with the things that work already" (e.g., creating and using a token system).
Follow-up session(s)	Mr. E. and his carer produced a detailed report about Mr. E.'s increasing control over his alcohol use, and Mr. E.'s success in finding leisure activities. The report also noted Mr. E.'s increase in green thoughts and the intention to celebrate the successes with a karaoke party.

SFBT, solution-focused brief therapy.

standardized GAS index,[1] described by Kiresuk and Sherman (1968). Improvement, in the present study, was defined as an increase of 10 points (or more) on this GAS index. The GAS was completed by carers during the therapy sessions.

Treatment strategy and therapeutic alliance Miller, Hubble, and Duncan (1996) developed the Session Rating Scale (SRS). A version of the SRS for children was adapted for use with people

[1]GAS score: $I = \text{index} = 10\ \Sigma\ W\ i\ Xi/\sqrt{[(1-P)\ \Sigma Wi^2 + P\ (\Sigma Wi)^2]}$, in which Xi = the score of the ith scale, Wi = the weight assigned to the ith scale, and P = the weighted mean intercorrelation between scales, estimated to be 0.30. If all goals are considered to be of equal weight, then $Wi = 1$ and the indices can be read from a table compiled by Kiresuk, Smith, and Cardillo (1994). The calculation procedure is such that with a large number of indices the average will be 50 with a standard deviation of 10. Increases on subscales of +2 (two goals) or +3 (three goals) are in accordance with an increase of the GAS index larger than the standard deviation (>10).

with ID by Westra (2008). In this adaptation, words that could be regarded as childish by adults with ID were replaced. The adapted items were: (1) "*the person did not*"—vs.—"*did listen to me*," (2) "*the subjects we talked about were not*"—vs.—"*were important to me*," (3) "*the way we worked was not good*"—vs.—"*was good for me*," and (4) "*something was missing in the treatment today*"—vs.—"*I enjoyed the treatment today*." At the end of each meeting, the person with MID provided the therapist with feedback on four areas: (1) the relationship, (2) goals and subjects, (3) strategy or method, and (4) the session. The person was asked to evaluate the consultation using a 10-cm-long line (the scale), representing each one of the four SRS dimensions. The left-hand end of the scale was represented by a sad face "smiley" (☹), and the right-hand end of the scale was represented by a happy face "smiley" (☺). The smileys were used to enable the adult to express satisfaction. The closest centimeter mark, indicated with a cross, to the right or the left determined the score. The SRS (version for adults) was investigated by Duncan, Miller, and Sparks (2004) and had good internal consistency (Cronbrach's α: 0.88) and reasonable stability (Pearson's r: 0.64). A statistically significant correlation (Pearson's r: 0.48; $p < 0.01$) was found between the SRS and an extensive list of questions with the same measuring pretension (therapeutic alliance). The authors of the SRS recommend asking the client to comment on an aspect of the treatment strategy or the therapeutic alliance, whenever a subscale score is below 9.

RESULTS

Quality of Life, Maladaptive Behavior, and Goal Attainment

This study focused on the differences before SFBT, directly after SFBT, and 6 weeks after SFBT, with regard to (1) quality of life, (2) maladaptive behavior, (3) goal attainment according to people with MID, and (4) goal attainment according to carers.

Quality of life In seven of the 10 adults, statistically significant improvements were evident directly after SFBT using the IDQOL subscale of psychological functioning. In two of 10 adults, the same was true for social functioning, and in four of 10 adults, this was true for quality of life composite score. During follow-up, the differences in psychological functioning and quality of life were sustained in six and four adults, respectively. For social functioning, two adults prolonged or improved positive changes, and two other adults showed improvements only at follow-up. These subsequent improvements of social functioning in the period after SFBT, and before follow-up, might be because some of the steps (toward the goals) required more time than the limited time allotment for the therapy. An example of this is one woman who organized a successful reunion with her sister 3 weeks after SFBT and 3 weeks before follow-up, resulting in a higher social functioning score.

The differences in scores of all 10 adults were statistically significant (Wilcoxon signed-rank test) for the measures of quality of life and psychological functioning (quality of life: session 1 vs. session 5; $z = -2.7$, $p < 0.01$; session 1 vs. follow-up: $z = -2.5$, $p < 0.01$; psychological functioning: session 1 vs. session 5; $z = -2.7$, $p < 0.01$; session 1 vs. follow-up: $z = -2.4$, $p < 0.01$). No statistically significant changes were seen between social functioning scores.

Maladaptive behavior In eight of the 10 adults, staff carers assessed that there were clinically relevant decreases of psychological problems directly after SFBT and during follow-up by means of RSMB scores. For two of the 10 people, this concerned decreases in psychological problems in one domain from the first to the fifth session, respectively, and the follow-up session (from 1 to 0 to 0 scores). For six of the 10 adults, there were decreases in several domains (from 6 to 3 to 1 domain; from 2 to 0 to 0 domains; from 7 to 4 to 5 domains; from 5 to 3 to 3 domains; from 7 to 5 to 3 domains and from 7 to 3 to 2 domains). In two adults, carers assessed no decreases in psychological problems from the first to the fifth session, respectively, and the follow-up session (from 1 to 1 to 1 domain). Table 3 lists the outcomes of the IDQOL-16 and the RSMB before SFBT, after SFBT, and 6 weeks after SFBT (follow-up).

Goal attainment according to people with MID Seven of 10 adults indicated progressions of two points or more (a clinically relevant difference) on SQP after SFBT, and these progressions were sustained during follow-up. The differences in scores of the 10 adults were statistically significant (SQP: session 1 vs. session 5; $z = -2.8$, $p < 0.01$; SQP: session 1 vs. follow-up: $z = -2.7$, $p < 0.01$).

Goal attainment according to staff carers In seven of the 10 adults, statistically significant improvements of the GAS index (>10 points) directly after SFBT and during follow-up were evident. Table 4 shows the outcomes of the SQP and of the GAS.

Opinions about the strategy and collaboration The third topic concerned the client's opinions about the strategies and of the collaboration between the therapist and people with MID, as measured by the SRS. All adults gave the minimal desired score of 9 to almost all of the item scores. Two incidental lower scores and the following feedback led to adjustments during therapy (e.g., "use simpler language and clarify the tasks" (score 7 on relationship and approach in session 2) and "give more attention to me and less to the caregiver" (score 8 on relationship in session 2)).

DISCUSSION

In most of the SFBT treatments described in this article, we observed improvements of psychological functioning, decreases in maladaptive behavior, and positive progressions toward the treatment goals according to both adults with MID and staff carers. Seven of 10 adults with MID reached their treatment goal measured by the SQP. For the others, the progression was 0–1 point. Two people (cases C_2 and C_3) at the first session were so driven to reach their goal (i.e., being in control of alcohol consumption during the weekend) that they instantly indicated high progression scores of 9 and 10. In these cases, clinically significant progression (SQP $\geq$ 2 points) was not possible. However, in both cases, progression toward the treatment goal was confirmed by carers by means of statistically significant improvements on the goal-attainment index (GAS > 10). The treatment strategies and

TABLE 3
Intellectual Disability Quality of Life (IDQOL): standard scores per case and Reiss Screen Maladaptive Behavior (RSMB): number of domains per case

SFBT session	Cases	C_1	C_2	C_3	C_4	C_5	C_6	C_7	C_8	C_9	C_{10}
IDQOL subscale: psychological functioning											
First session	Raw score	1	3	1	1	1	1	1	1	1	2
Fifth session	Raw score	2[a]	3	3[a]	2[a]	2[a]	2[a]	1	1	2[a]	3[a]
Follow-up	Raw score	1	3	3[b]	2[b]	3[b]	3[b]	1	1	2[b]	3[b]
IDQOL subscale: social functioning											
First session	Raw score	1	1	3	1	1	1	1	1	1	1
Fifth session	Raw score	2[a]	1	3	1	2[a]	1	1	1	1	1
Follow-up	Raw score	2[b]	1	3	1	3[b]	2[b]	2[b]	1	1	1
IDQOL subscale: quality of life											
First session	Raw score	2	3	4	2	2	1	1	1	1	2
Fifth session	Raw score	5[a]	3	5	3	6[a]	4[a]	1	2	3[a]	3
Follow-up	Raw score	4[b]	3	5	3	6[b]	6[b]	2	2	4[b]	3
Reiss screen for maladaptive behavior											
First session	Domains	6	1	1	2	7	1	5	7	7	1
Fifth session	Domains	3[c]	0[c]	0[c]	0[c]	4[c]	1	3[c]	5[c]	3[c]	1
Follow-up	Domains	1[d]	0[d]	0[d]	0[d]	5[d]	1	3[d]	3[d]	2[d]	1

[a]Positive difference: the differences were statistically significant: increase of ≥1 point (= 1 quartile or 25% improvement) in the subscales *psychological* and *social functioning* and an increase of ≥2 points (= 2 deciles or 20% improvement) in the subscale *quality of life*.
[b]Sustained positive statistically significant difference at follow-up.
[c]The decrease of the number of domains was clinically significant.
[d]Sustained decrease at follow-up.
SFBT, solution-focused brief therapy.

TABLE 4
Goal attainment according to clients (SQP) and according to caregivers (GAS)

	Case Nr.	C_1	C_2	C_3	C_4	C_5	C_6	C_7	C_8	C_9	C_{10}
Goal attainment according to clients (SQP)											
After SFBT	Scale score	+3[a]	+1	+1	+5[a]	+3[a]	+3[a]	+1	+2[a]	+3[a]	+2[a]
Follow-up	Scale score	+3[b]	+1	+1	+5[b]	+2[b]	+4[b]	+1	+3[b]	+3[b]	+2[b]
Goal attainment according to caregivers (GAS)											
Number of goals		3	2	2	3	3	2	2	2	2	2
After SFBT	Scale score[e]	+2	+2[c]	+3[c]	+3[c]	+3[c]	+2[c]	+1	+1	+2[c]	+2[c]
	GAS index[f]	59	62[c]	69[c]	64[c]	64[c]	62[c]	56	56	62[c]	62[c]
Follow-up	Scale score[e]	+2	+2[d]	+3[d]	+3[d]	+4[d]	+3[d]	+1	+1	+3[d]	+2[d]
	GAS index[f]	59	62[d]	69[d]	64[d]	68[d]	69[d]	56	56	69[d]	62[d]

[a]Positive difference: the differences were clinically significant (≥ +2 points on the SQP).
[b]Sustained positive difference at follow-up.
[c]Positive difference: the differences were statistically significant (≥ +2 for two goals; ≥ +3 for three goals; >10 for the GAS index).
[d]Sustained positive difference at follow-up.
[e]The scale of the GAS at the start of therapy is zero.
[f]The GAS index at the start of therapy is 50.
SFBT, solution-focused brief therapy; SQP, Scaling Question Progression; GAS, Goal Attainment Scaling.

therapeutic alliances were generally assessed as positive by the people with MID (score of 9 and higher). Discussions about the lower scores led in all cases to workable adjustments (e.g., by clarifying tasks after SFBT using pictograms). These results seem to indicate that SFBT could constitute a valuable contribution to the support of people with MID.

Our research study has had some limitations. The first is how we chose our participants. They were selected by staff at the provider and not randomly. This may affect our results as there may have been an inclination by the chosen adults to be helpful and more compliant. Second is the instrumentation. Any choice of standardized measurement instruments automatically implies restrictions. During SFBT, as every person formulated his or her own goal, it is possible that the chosen goal did not sufficiently match the measuring pretension of the instruments used. This does not apply to the SQP because this measurement adjusts itself to the goal of the individual and is therefore not considered a standardized measurement instrument. It was true for the IDQOL because the domains of psychological and social functioning within this instrument were broad and could differ from what people with MID found relevant to measure. Moreover, it is difficult to conclude from this study whether the improvements advanced by participating in SFBT can be seen holding over time. Even though SFBT is considered a brief therapy, it was expected that SFBT could assist people with MID in reaching their goals, could improve their psychological and social functioning, and could reduce psychological problems in a relatively short time. Although some gains were made by the interventions, it remains uncertain if these improvements will last over time (e.g., longer than 1 year). A third limitation was our design. We used a design that did not draw up a control group. We only studied a treatment group and compared measurements taken before SFBT, after SFBT, and at follow-up. Without comparison data from a control group, it cannot be excluded that the treatment goals of the participants could not have been reached without SFBT. In addition, the small number of participants limits generalization of the findings. To what extent our findings will apply to other people with MID is unknown. However, despite these limitations, the fact that several case studies showed positive treatment results does point to the potential of using SFBT for people with MID. Further research into the effects of SFBT that includes a control group is needed to further assess the value of SFBT.

We conclude that SFBT provides an additional approach of available therapeutic approaches for use with people with ID. There are several reasons why we make this statement.

First, SFBT focuses on skills rather than on deficits and recognizes the expert status of people with MID. This is in line with the present view of ID that focuses on empowerment. Second, we agree with Stoddart et al. (2001), who, in noting the strengths of using SFBT with people with ID, said "SFBT 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 and positive relationship between clients and therapists" (p. 36). Third, SFBT encourages the involvement of carers in the therapeutic process. Because of their involvement in SFBT, professionals may develop more positive perspectives on the people with MID and may become more aware of their resiliencies, resources and competencies, and in particular their abilities to come up with solutions themselves (Lloyd & Dallos, 2006, 2008). Finally, there is evidence (MacDonald, 2007) that SFBT works equally well for all socioeconomic groups. Although it was exploratory, this study's findings are important because most psychotherapy research and many psychiatric studies show that outcomes are generally better for the higher socioeconomic groups. Yet, people with MID are often economically disadvantaged and usually belong to lower socioeconomic groups. The findings that they too can benefit from SFBT is encouraging. We therefore can conclude that SFBT can be regarded as a valuable therapy, although we would also propose that further research in this area is needed.

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