

# Solution-Focused Coaching of Staff of People With Severe and Moderate Intellectual Disabilities: A Case Series

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**Abstract** Solution-focused coaching (SFC) represents a short-term, future-focused, and person-directed therapeutic approach that helps people focus on solutions rather than problems. Thirteen cases of SFC of staff dealing with people with severe and moderate intellectual disabilities (S/MID) are described. In all 13 cases, the progress toward the team goal, proactive thinking of staff, and the quality of the relationship (QOR) between staff and people with S/MID were measured directly before SFC, directly after SFC, and 6 weeks after SFC. After SFC, progress toward the team goal was found in seven out of 13 teams, improvement of proactive thinking was found in 5/10 teams and improvement of the QOR was found in 7/13 teams. With regard to individual staff members, improvement of proactive thinking was found in 12/34 staff members and improvement of the QOR was found in 22/42 staff members. The authors note that SFC stimulates dealing with support problems in a behavioral, proactive way and that SFC can be a useful approach to build useful relationships. The findings are in line with results of earlier research on the value of solution-focused brief therapy applied to carers (parents or professionals) of people with ID. Future investigation of SFC, preferably using a randomized controlled design, could test the hypothesis that SFC can increase self-efficacy and proactive thinking in teams, can positively alter staff's perceptions of people with ID, and that teams find it a useful approach.

**Keywords:** intellectual disabilities, solution-focused coaching, systemic therapy

## INTRODUCTION

Recently, there has been an expansion in therapeutic interventions offered to people with intellectual disabilities (ID) in order to decrease problems or to increase the quality of support or quality of life. These approaches include those that focus on family and carer systems (Collins, 1999; Fidell, 2000; Frankish & Terry, 2003; Willems, Embregts, Stams, & Moonen, 2010). In this range of therapies, solution-focused brief therapy (SFBT; De Shazer, 1985) is a relatively new, behaviorally orientated therapy. As applied to adults with ID, SFBT represents a short-term, future-focused, and person-directed therapeutic approach that helps people focus on solutions rather than on problems. Solution-focused coaching (SFC, see later) is based on SFBT. One of the central assumptions of SFBT is that the client defines the goal of the therapy and that the client has the competencies and resources to realize this goal. The person is invited to describe what will be different in the future once his or her goal

is reached (*goal setting*). This could be done by means of the *miracle question*: "Imagine a miracle occurring tonight that would (sufficiently) solve the problem, what will you be doing differently? How will other people know that things have improved?"

Another important element in SFBT is *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 what is done to realize these exceptions. *Scaling questions* (10 = "very good" to 0 = "very bad") are used in order to measure progress during therapy. These questions also are used to measure and stimulate hope, motivation, and confidence that the goal can be reached. In this way, this helps the client move away from "all or nothing" goals, and strive for smaller, manageable, and measurable steps. The therapist promotes descriptions of progress in these specific, small, behavioral steps. To stimulate or maintain changes, the therapist suggests homework assignments such as "continue with what is working already." During SFBT, the relationship (visitor, complainant, or customer relationship) with the person is assessed. In a visitor relationship, the person is mandated or referred by others. He or she does not voluntarily seek help and is not experiencing emotional difficulties. In a complainant relationship, the person is experiencing emotional difficulties. However, he or she does not (yet) or does

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not any longer see himself or herself as part of the problem and/or the solution. In a customer relationship, the person experiences a problem and sees himself/herself as part of the problem and/or solution, and is motivated to change that behavior. Each type of relationship requires a different approach by the therapist (Bannink, 2010; Roeden & Bannink, 2007).

SFBT does not focus on people with ID specifically, but is suitable for them with some adaptations. Several authors suggest adjustments to SFBT for people with ID, due to their specific needs, developmental levels, and abilities (Corcoran, 2002; Lentham, 2002; Smith, 2005, 2006). With these adjustments, SFBT was shown to be useful for people with mild ID (Roeden & Bannink, 2007; Roeden, Bannink, Maaskant, & Curfs, 2009; Roeden, Maaskant, Bannink, & Curfs, 2011; Smith, 2005, 2006; Stoddart, McDonnell, Temple, & Mustata, 2001).

### *Rationale for Utilizing SFC With Staff*

SFBT with people with profound, severe, or moderate ID is not possible, because they lack sufficient verbal and cognitive abilities to describe their goals, perform homework assignments, and evaluate their progress. In these instances, SFC by staff working with people with profound, severe, or moderate ID may provide an alternative (Westra & Bannink, 2006a, 2006b). SFC in fact is the same as SFBT, albeit that the people in SFC are not individuals (with ID) but staff members of a team (for people with ID). In SFC, the team formulates a goal and a strategy to reach this goal. In this process, the therapist is called a coach. However, little is known about the usefulness of SFC for staff working with people with ID. Only scant research on this topic is available (Lloyd & Dallos, 2006, 2008; Rhodes, 2000; Stoddart et al., 2001). Rhodes (2000) found that SFC is a useful approach for staff working with people with ID. In particular, the focus on strengths was valued and the way staff members generated solutions that built on their competencies. Stoddart et al. (2001) treated 16 people with mild ID and with a range of problems using SFBT. They also actively involved staff in the treatment procedures. Staff members developed more positive perspectives about the persons because of their involvement in SFBT. They became more aware of each person's resiliencies, resources, and competencies, and, in particular, the person's abilities to come up with solutions himself or herself. Lloyd and Dallos (2006, 2008) found that mothers of children with severe ID experienced SFC as a useful approach to build useful relationships, to highlight self-efficacy, and to encourage helpful coping styles. As Wheeler (2001) reported, SFC can be particularly helpful for carers in encouraging a sense of self-efficacy and proactive thinking, in altering negative perceptions, and in enhancing positive attachment.

Several studies regarding the process of SFC (Bozeman, 1999; Jordin & Quinn, 1994; Quick & Gizzo, 2007; Shilts, Rambo, & Hernandez, 1997) found that the solution-focused techniques increase clients' hopes and expectations to accomplish their goals. Other studies (Bonsi, 2005; Gingerich, de Shazer & Weiner-Davis, 1988; Speicher-Bocija, 1999) demonstrated that clients were also more likely to talk about positive change when solution-focused coaches asked about successes and exceptions to problems or focused on goals. Corcoran and Ivery (2004)

demonstrated a positive association between clients' strengths identified by coaches and positive outcomes.

Recent research highlighted that staff supporting persons with ID experience moderate levels of burnout (Skirrow & Hatton, 2007). Violent client behavior (Hatton, Brown, Caine, & Emerson, 1995), high support needs (Dyer & Quine, 1998), imbalanced relationships with clients (Van Dierendonck, Schaufeli, & Buunk, 1996), and challenging behavior (Chung & Harding, 2009; Jenkins, Rose, & Lovell, 1997; Prosser et al., 1997) have been shown to be associated with higher levels of burnout and other negative psychological outcomes. In dealing with all these support problems, SFC could be useful, because it offers staff a hopeful, outcome-oriented, competence-based set of interventions.

### *Aim of this Study*

To obtain more information on the usefulness of SFC in staff working in the ID field, we conducted an exploratory study of 13 SFC procedures with teams of staff members. These teams had trouble in supporting people with severe and moderate ID. We expected that SFC (a) could assist teams in reaching their team goals; (b) could improve proactive thinking in teams; and (c) could positively influence the relationship between staff and people with ID. In addition, we expected that staff would appreciate SFC. We therefore explored three topics. First, we described the treatment protocol. Second, we measured differences directly before SFC, directly after SFC, and 6 weeks after SFC, with regard to (a) progression toward the goal during SFC according to staff; (b) proactive thinking in teams; and (c) the quality of the relationship (QOR) between staff and people with S/MID. Third, we measured the staff members' opinions of the SFC procedure and of the collaboration between coach and staff.

## METHOD

### *Participants and Procedures*

The study was conducted at a service provider for children and adults with ID (approximately 900 people) in the Netherlands. People with ID use the residential services of this service provider, as well as services such as respite care, day care, and home care. The service provider offers therapies, such as behavior therapy and SFBT to its clientele. SFC is offered as well to staff teams.

Staff members involved in this study were direct care workers who provided residential or vocational support for people with ID. Forty-two staff members (all females), working in 13 teams, participated in this study. The teams consisted of two to four staff members. The mean age of staff members was 40.4 years (SD = 11.1 years). Years worked in the ID sector ranged from 1 year to 33 years, with a mean of 12.7 (SD = 8.6 years). Of the staff, some 46% were employed as direct care staff, and 54% as occupational therapy staff. Of the staff, 95% had a 3-year professional training in nursing, social work, or occupational therapy, which is standard in the Netherlands for direct care staff. Of

these, 5% had a high school degree in nursing, teaching, or social science. The staff, who worked at the service provider agency and experienced a support problem with a client with ID, could apply for SFC with solution-focused coaches. The staff mentioned support problems such as violent client behavior, imbalanced relationships (e.g., “we give more than we receive”), communication problems, and lack of progress with clients. Staff members gained a global understanding of SFC through attending an information meeting and by reading literature that was provided (Roeden et al., 2009). The two solution-focused coaches in this study had a master’s degree in counseling. Their additional training program on SFC included the history and philosophy of SFC, the tenets of SFC, session format, and structure of SFC, video examples of founders of SFC, and role-playing and supervised practice with clients with ID.

Permission for the study was granted by the Client Council (comprised of service users with ID) and by the Representative Council (comprised of family members or representatives of service users with ID) of the service provider. The Councils confirmed that the study complied with the local organizational guidelines for internal evaluation. All participants in the study agreed to anonymous publication of the research data.

### Treatment Protocol

As part of study, 13 teams participated in SFC. For every case, measurements were taken directly before SFC, directly after SFC, and 6 weeks after SFC. The SFC process according to session, intervention, and description is summarized in Table 1. During intake (session 1), the SFBT coach becomes acquainted with staff members through enquiries about the competencies of individual staff members and of the staff as a team. Subsequently, the support problems experienced by the staff are explored. Two questions are then asked: “What is the support problem with this person?” and “What is the problem for staff members?” The support problem focuses on one particular person with severe to moderate ID. During session 1, the coach asks solution-focused questions, such as questions concerning the goals of staff, exceptions, scale questions, and competency questions. Every session concludes with the coach giving feedback to staff members. A detailed example of a solution-focused consultation is described in Table 2.

In session 2, the coach starts with the EARS question set. EARS is an acronym for Eliciting, Amplifying, Reinforcing, and Start again. It outlines the therapeutic process. The first question is “What is better?” (Eliciting). Staff members can respond to that question in four different ways: “It is better,” “There is no change,” “It is worse,” or “There is a difference in opinions” (in this case, between staff members). If it is better, the coach can 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 can also be utilized when the staff believe that there is no change. The coach acknowledges the staff when they feel disappointed, and emphasizes that keeping a situation stable is an accomplishment and can sometimes be the highest achievable goal at that moment. The coach reviews with staff members how they accomplished that stability. When the situation becomes worse, the coach also

acknowledges staff members if they were disappointed, and a reorientation to the goal could be necessary. Alternatively, the coach can ask how the staff were able to persevere under such difficult circumstances, which might then open up the discussion to the EARS set of questions. If there is a difference in opinions between staff members about the amount of progress, the coach first normalizes this situation by establishing that progress usually occurs in a systematic fashion and through trial and error. Subsequently, small improvements can be explored through EARS (Bannink, 2010). Consolidation questions (Selekman, 1993) were used at the end of the sessions to increase the likelihood that the staff would keep on working on the desired goals. An example of such a consolidation question is: “What do you have to keep doing to make sure that these results keep happening?”

**Measures** Measures focused on coaching effects of SFC (progression toward the goal, proactive thinking, and quality of relationship between clients and staff) and also on staff members’ opinions about the SFC procedure and the collaboration between coach and staff.

**Progression toward the goal** The Scale Question Progression (SQP; Bannink, 2010) ranges from 10 (most desirable support situation) to 1 (least desirable support situation). It indicates the extent to which a team goal has been approached or has been reached. The SQP was rated by all staff members independently. The scores used for analyses were average scores for each of the 13 teams. In solution-focused scale questioning, it is customary to ask the people concerned what they regard as a relevant improvement. In this study, the members of the 13 teams were asked about such an improvement. They decided that an average progression of 2 points could be regarded as a relevant improvement.

**Proactive thinking** Proactive thinking was measured using part of the Staff–Client Interactive Behaviour Inventory (SCIBI; Willems et al., 2010). The 30-item SCIBI measures both intrapersonal staff behavior (proactive thinking, self-reflection, critical expressed emotion) and interpersonal staff behavior (assertive control, hostile, friendly and support-seeking behavior) in response to challenging behavior of people with ID. These seven factors were supported by a factor analysis (Willems et al., 2010). The internal consistency of the SCIBI was satisfactory (Cronbach’s alpha >.68) for all scales. Staff members were asked to complete the SCIBI scale of proactive thinking (abbreviated as: SCIBI-PAT). The SCIBI-PAT is a three-item self-report questionnaire using a 5-point Likert scale, ranging from completely inapplicable (1) to completely applicable (5). The items are: “In working with this client, I think about *how*, (first item), *what* (second item) or *why* (third item) I am going to do things.”

**QOR between the staff and people with ID** The relationship between people with ID and the staff members was measured using the Student Teacher Relationship Scale (STRS, authorized translation; Koomen, Verschuere, & Pianta, 2007; Koomen, Verschuere, Van Schooten, Jak, & Pianta, 2012). The 28-item STRS represents the view of the teacher on three relationship dimensions: closeness (11 items), conflict (12 items), and dependency

TABLE 1  
 SFC protocol according to session, intervention, and description

Session	Intervention	Description
Intake	1. Getting acquainted	The coach spends time to get to know the team. Competencies and resources are explored.
	2. Exploring the problem	The coach invites the team to describe their problem and/or to mention their goal for coaching. The coach acknowledges the problems of the team.
First Session	3. Pre-session change	Since most teams have tried other possibilities before connecting with a coach. The coach can ask whether and/or what changes have already occurred before the first session.
	4. Goal-setting	The team is invited to describe what would be different once their 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 coach may also suggest that changes are possible (e.g., "When you look forward and things have improved, what will you be doing differently?") or by using the video question: "Suppose we make a video showing the most desirable support situation. What do we see and hear on this video?"
	5. Exploring the exceptions	The coach inquires about moments in the past or present when the problem does not occur or is less serious and who does what to bring about these exceptions.
	6. Scaling questions	On a scale of 10 to 1, the team indicates their progression toward their goal. Scaling questions help the team to move away from all-or-nothing goals toward manageable and measurable steps.
	7. Competence questions	By using competence questions, self-compliments are provoked with the team. "How do (did) you do that?" Direct compliments aim to highlight something the team has done, made, or said.
	8. The question: "What else?"	The coach may also indicate with the question "What else?" indicating that there is more to come. Teams often respond to this simple query by giving more information and ideas.
	9. Feedback	At the end of every session, feedback with compliments and usually some homework are given. The compliments emphasize what the team is already doing to reach their goal. The suggestions indicate areas requiring the team's attention or possible further actions needed to reach their goal. Between the components of compliments and suggestions/tasks, a reason (or bridge) is given to perform those tasks.
Follow-up sessions	10. The question: "What is better?"	The standard beginning question is: "What is better?"
	11. EARS = Eliciting, Amplifying, Reinforcing, Start again	Eliciting, amplifying, and reinforcing of (small) successes, exceptions to problems, or descriptions of the desired future and the invitation to the team to do that again or more often.
	12. Feedback	Compliments—reason/bridge—task
	13. Consolidation	Consolidation questions such as: "What do you have to keep doing to make sure that these results keep happening? How are able to stay on track?"

SFC, solution-focused coaching.

(five items). The total STRS score represents the QOR. In consultation with the author of the STRS, the terms "student" and "teacher" were substituted by "person with ID" and "staff member," respectively. Staff rated the extent to which they agreed with each statement (for example: "I share an affectionate, warm relationship with this person") using a 5-point Likert scale, ranging from "definitely does not apply" (1) to "definitely

applies" (5). Closeness reflects the degree of openness, warmth, and security in the relationship according to the teacher/staff member. Conflict refers to the degree to which a teacher/staff member perceives interactions as negative, discordant, unpredictable, and unpleasant. Dependency denotes the developmentally inappropriate degree of overreliance and possessiveness of the child/adult with ID in the relationship. Psychometric

TABLE 2  
 Case example of SFC team session—The support of “L”

Session intervention	Query	Process
Getting acquainted	“What are the strengths of this team and the individual staff members?”	Positive staff member characteristics were being flexible and open minded, and able to critically assess own actions. L. was viewed as a spirited woman, full of temperament and her willfulness was appreciated.
Exploring the problem	“What is the support problem? What is the problem for staff members?”	There were many conflicts with L. Staff members could not get through to her and were often frustrated. Other people were bothered by L.’s grumpy and meddlesome behavior and were afraid of her. There was no harmony between the staff and L.
Pre-session change	“What has changed since the application?”	Since the intake, staff members had given thought to their negative relationship with L. and had adjusted their approach. They asked her informative questions about leisure activities more often. They started each day with an open mind about her, even when she entered the room in a grumpy mood, and they gave her compliments more often.
Goal setting	“Suppose we make a video in the near future, showing how well staff will interact with L. What are some of the things you would like to see and hear on that video?”	Staff wanted good harmony with L. The video question was answered as follows: “We would be attentive, inviting, and complimentary toward L.” Staff members subsequently gave descriptions of concrete actions: “We would have short conversations with L. six times a day, we would take adequate time to show interest in L.’s stories, photographs, and drawings, about things she recently encountered, and we would say that we appreciate her sharing these things with us.” Staff also described a (video) image of their changed opinions of L. during collegial dialogues: “From now on we no longer call the interaction of L. with some other people meddlesome; instead we will call it helpful.”
Exploring exceptions	“When does the problem not occur or is it less serious?”	Staff members described a part of the day when they were satisfied about their interaction with L.: “Take for example the time we cleaned the rabbit hutch. We were paying attention especially to things that L. already did well, like refilling the water dish. We found it really rewarding to encourage her in that task and, in the mean time, simplify for her the more difficult task of giving food.”
Scaling questions	“Suppose 10 = a good relationship between staff and L. and 1 = a poor relationship between staff and L. What number would you give?”	Staff members indicated an average number of 4.5 as a start and wanted to strive for an average number of 8.0. One step forward (from 4.5 to 5.5) would mean that staff members daily gave positive attention for 5 min to L. at a number of specified moments.

SFC, solution-focused coaching.

research in school settings showed a satisfactory internal consistency for all scales (Cronbach’s  $\alpha$  between .77 and .90). The STRS domains of closeness, conflict, and dependency were supported by a factor analysis. Roeden, Maaskant, Koomen, Candel, and Curfs (2012) studied the psychometric qualities of the STRS in an ID setting. The factor structure matched with the factor structure found in educational settings. The internal consistency was good for all subscales and the total score (Cronbach’s  $\alpha$  between .81 and .89), as well as the test–retest reliability (intraclass correlations coefficients between .85 and .92). In the present study, the staff completed the STRS, and their raw scores were averaged per team, resulting in mean scores per team.

#### Procedure and Collaboration

The assessment of the staff about the procedure and the collaboration was measured using the Session Rating Scale (SRS). The SRS (Duncan, Miller, & Sparks, 2004) is a short list of four items, evaluating each conversation about the procedure and the collaboration between the solution-focused coach and staff members. The items refer to: (a) the relationship, “I felt I wasn’t (versus I was) listened to, understood and respected”; (b) goals and subjects: “We did not (versus we did) talk about the subjects I wanted to talk about”; (c) the procedure or method: “The way in which the coach approaches my problems does not match

(versus does match) my style”; (d) total session: “Something was missing in the contact we had today (versus, in general, I found the contact we had to be OK).” The four items were represented by four visual analogue scales of 10 cm. The left end of the line (score = 0) represented the most negative response, the right end (score = 10) the most positive response. The closest centimeter mark, indicated by a cross, determined the score. The authors of the SRS recommend asking the respondent to comment on (an aspect of) the coaching strategy or the collaboration whenever a subscale score is below 9. Duncan’s research found that the SRS had a good internal consistency (Cronbach’s  $\alpha$ : .88) and a reasonable stability (Pearson’s  $r$ : .64). Factor analysis was not conducted because of the small size of the list (four items). The SRS is intended to stimulate the discussion between therapists and clients about the treatment (in the present study: between coach and staff), and—based on that—to improve the procedure and collaboration. In this study, the SRS was completed in every session.

### Analyses

The SCIBI-PAT and STRS data were analyzed both on the team level and on individual level. In this way, it was measured whether or not teams as a whole did profit from SFC, rather than only measuring the (possibly contrasting) changes of individual staff members. The SQP scores were average teams’ scores and were only analyzed on the team level, because this goal was set and defined by the teams as a whole. Because of the relatively small sample size of teams ( $n = 13$ ), a nonparametric test (Wilcoxon signed-rank test) was used to analyze the team data. The Wilcoxon signed-rank test is a nonparametric statistical hypothesis test for repeated measurements. Scores of individual staff members were compared by means of the paired  $t$ -test. The paired  $t$ -test was used to compare the values of means from two related samples (e.g., before and after an intervention).

Statistically significant differences in scores between teams do not reveal differences between individual staff members per se. Therefore, the Reliable Change Index (RCI; Jacobson & Truax, 1991) was used. The RCI is a statistic that determines the magnitude of change, necessary of a given individual self-report measure, to be statistically significant. The RCI for individual staff members is computed as follows:  $RCI = (x_2 - x_1) / S_{diff}$ , where  $x_1$  represents a person’s pretest score and  $x_2$  represents that same subject’s post-test score.  $S_{diff}$  is computed from the standard error of measurement:  $(\sqrt{2} (S_E)^2)$ . When the RCI is larger than 1.96 ( $p < .05$ ), it is likely that post-test scores reflect real changes. RCIs of SCIBI-PAT scores and STRS scores were computed for both individual staff members and teams. The staff’s opinion about the SFC procedures was analyzed qualitatively by using the SRS.

## FINDINGS

### Treatment Protocol

The average duration of SFC (session 1–3) with the teams was 9 weeks. A variety of supporting problems were reported by

the staff such as: “We have too many conflicts with this person”; “We are insufficiently involved with this person”; “We are inadequately able to reduce aggression in this person.” These problems resulted in goals formulated by teams, such as: “When working with this person we want harmony . . .,” “we want involvement . . .,” “we want safety . . .,” and so on.

The first topic of this explorative study was about the conduct of SFC of staff working with people with severe to moderate ID. To proffer insight into SFC, an extensive description is provided of the first SFC session of team 1 regarding their support of L., a woman with moderate ID in Table 2. The SFC-process includes getting acquainted, exploring the problem, pre-session change, goal setting, exploring the exceptions, scaling questions, and feedback. In this case, these interventions were dealt with as described in Table 2.

Staff viewed themselves as part of the problem and/or solution (customer-relationship). The coach complimented staff members for their interest and involvement in L. and thought that these staff characteristics would lead to a good relationship with her. The coach subsequently proposed a number of tasks. Observation task: “Notice when the relationship between you and L. is good and tell me more about that next time.” Behavioral tasks: “Keep doing what already works (e.g., start for example each day open minded and pay attention to (partial) tasks that are already being executed well by L.) and do part of the portrayed video image (e.g., react attentively, spontaneously and inviting toward L. at specific points during the day).”

In follow-up sessions, the staff reported that things were going better. The coach asked for details about the improvements, explored meticulously the exceptions to the support problem, and reinforced the successes. At the end of the SFC, the staff reported that good harmony with L. was established.

### Progression Toward the Goal, Proactive Thinking in Teams, and the QOR

This study also focused on differences directly before SFC, directly after SFC, and 6 weeks after SFC, with regard to (a) progression toward the goal during SFC according to staff; (b) proactive thinking in teams; and (c) the QOR between staff and people with severe to moderate ID (designated as topic 2). Table 3 lists the average scores and changes in scores on the SQP (goal attainment), the average scores and changes of the SCIBI-PAT (proactive thinking), and the average scores and changes of the STRS (QOR), as well as the test statistics for all variables.

*Progression toward the goal* Progression toward the goal was analyzed on the team level. Directly after SFC, it showed that the teams experienced a statistically significant increase in goal attainment. The mean increase directly after SFC was 1.9 points (from 5.3 to 7.2). Further analyses showed that seven out of the 13 teams indicated a substantial progression toward the team goal (i.e., 2 or more points) on the SQP. Four other teams experienced an increase as well, but this increase was between 1 and 2 points; two teams showed hardly any changes (less than 1.0 point after SFC). At follow-up, the mean increase of the teams was 2.2 points (from 5.3 to 7.5). Results also showed that nine

TABLE 3

Differences in proactive thinking (PAT) and quality of the relationship (STRS) of the before, after, and follow-up measurements of individual staff members and of teams

Individual staff members									
Scales	N	n <sup>c</sup>	Session 1 Mean	Session 3 Mean	Mean change; t-test	n <sup>c</sup>	Follow-up Mean	Mean change; t-test	
PAT	34	12	11.1	12.1	+1.0 t = 3.5 <sup>a</sup>	15	12.3	+1.2 t = 4.8 <sup>a</sup>	
STRS	42	12	41.4	45.2	+3.8 t = 5.1 <sup>a</sup>	15	45.1	+3.7 t = 3.3 <sup>a</sup>	
Closeness	42	19	29.3	23.6	-5.7 t = -6.2 <sup>a</sup>	20	24.1	-5.2 t = -5.6 <sup>a</sup>	
Conflict	42	1	17.2	17.1	-0.1 t = -0.4 <sup>b</sup>	2	16.9	-0.3 t = -1.0 <sup>b</sup>	
Dependency	42	22	96.9	106.5	+9.6 t = 6.8 <sup>a</sup>	22	106.1	+9.2 <sup>a</sup> t = 5.7 <sup>a</sup>	
STRS									
Quality of relationship									
Teams									
	N	n <sup>c</sup>	Session 1 Mean	Session 3 Mean	Mean change; Wilcoxon test	n <sup>c</sup>	Follow-up Mean	Mean change; Wilcoxon test	
SQP	13	7	5.3	7.2	+1.9 z = -3.2 <sup>a</sup>	9	7.5	+2.2 z = -3.2 <sup>a</sup>	
PAT	10	5	11.1	12.1	+1.0 z = -2.6 <sup>a</sup>	6	12.3	+1.2 z = -2.7 <sup>a</sup>	
STRS	13	2	40.9	44.7	+3.8 z = -2.9 <sup>a</sup>	2	44.7	+3.8 z = -2.1 <sup>a</sup>	
Closeness	13	7	29.1	23.8	-5.3 z = -3.0 <sup>a</sup>	9	24.0	-5.1 z = -2.6 <sup>a</sup>	
Conflict	13	0	17.0	17.0	0 z = -0.6 <sup>b</sup>	0	16.9	-0.1 z = -0.1 <sup>b</sup>	
Dependency	13	7	96.8	105.9	+9.1 z = -3.1 <sup>a</sup>	7	105.7	+8.9 z = -2.6 <sup>a</sup>	
STRS									
Quality of relationship									

<sup>a</sup>Positive difference: the differences between before and after measurements are statistically significant ( $p < .05$ ) on paired *t*-test or Wilcoxon ranked-sign test.

<sup>b</sup>Difference is not statistically significant.

<sup>c</sup>Number of staff members or teams with SQP improvements  $\geq 2$  points or with a Real Change Index (RCI)  $> 1.96$ ; ( $p < .05$ ).

out of 13 teams indicated a progression of 2 or more points. All the aforementioned increases were statistically significant ( $p < .05$ ).

*Proactive thinking* PAT scores were used to gain insight into the staff members' proactive thinking. Directly after SFC, the mean increases on SCIBI-PAT scores were 1.0 point (individual staff members: from 11.1 to 12.1) and 1.0 point (teams: from 11.1 to 12.1). These differences both were statistically significant ( $p < .05$ ). At follow-up, these differences were slightly larger (respectively, 1.2 and 1.2 points) and both statistically significant ( $p < .05$ ). Only 34 staff members (10 teams) completed the

SCIBI-PAT. The SCIBI (including the PAT) published after the study began was not available for the first three teams that applied for SFC. However, the SCIBI was available for the remaining 10 teams (respectively eight staff members) that participated in this study. Real change (RCIs  $> 1.96$ ) in proactive thinking was found in 12 of the 34 staff members and in five out of 10 teams after SFC. At follow-up, that was true for 15 of the 34 staff members, and in six out of 10 teams.

*QOR* The QOR between people with ID and staff members was measured using the STRS. Both individual staff members and staff in general experienced statistically significant increases

in the quality of relationship ( $p < .05$ ). Individual staff members scored 9.6 points higher directly after SFC and 9.2 points higher at follow-up (from 96.9 to respectively 106.5 and 106.1). For teams, these increases were 9.1 and 8.9 points (from 96.8 to respectively 105.9 and 105.7). A real change (RCIs  $>1.96$ ) of the relationship was measured in 22 of the 42 staff members and in seven out of 13 teams directly after SFC and also at follow-up. These improvements in the QOR (both RCI and statistical significance) were due to decreases in STRS conflict scores and/or increases of STRS closeness scores. No real changes (RCIs) or statistically significant changes were seen between STRS dependency scores.

#### *Staff Opinions About the Procedure and of the Collaboration Between Coach and Staff*

The STRS was used to obtain the staff members' opinion of the procedure and of the collaboration between coach and staff (designated the third topic). Scores below 9 on the items *relationship, goals and subjects, procedure or method, or total session* were reasons for the coach to investigate what, according to staff members, could be improved concerning the procedure or collaboration. In most instances, the staff members gave scores of 9 or higher on all items. In one team, however, lower scores were given (7 and 8) on item 3 (procedure or method). A few staff members believed that SFC could not sufficiently contribute to reaching the goal (i.e., handling aggression). A recent unfavorable relocation of the person was seen as an explanation for worsening of behavior (continuing aggression). In addition, in two teams, staff members gave scores of 7 and 8 respectively on item 4 (the session as a whole) and commented that some steps toward the goal took more time than the duration of the coaching trajectory (session 1 through 3). Staff also commented on high scores (9 and higher) on the SRS such as "We now pay attention to competencies, successes, and positive exceptions to supporting all our people"; "SFC has resulted in a better relationship with this person"; "These Solution-Focused questions motivated us in a pleasant way to have detailed thoughts about our work"; "SFC makes us more aware of our own actions"; and "SFC makes us convinced that we can accomplish the things we want to accomplish."

## DISCUSSION

The goal of SFBT is to help people make the desired changes in their lives, or, as in the present study, through SFC, to help the staff make the desired changes in their work (Bannink, 2010). Measurements before and after SFC have shown that in several areas, (a) goal attainment, (b) proactive thinking, and (c) quality of relationship, positive changes occurred, which demonstrated that SFC could be a valuable approach for the staff working with people with severe to moderate ID.

All teams indicated progress toward the team goal. However, seven out of the 13 teams scored above the cutoff point of 2, and two teams showed hardly any changes (less than 1.0 point after SFC). The complexity of the support problem was said to be the

cause of this lack in progress. The staff also mentioned that improvement hardly was possible after such a short period of time. We agree that SFC stimulates dealing with support problems in a behavioral, proactive way (Wheeler, 2001). Improvement of proactive thinking was found in five out of 10 teams after SFC and in six out of 10 teams at follow-up. It might be possible that differences in the experience of staff could account for this absence of progress. In addition, former experiences of the staff, and consequently how they support clients, could have influenced the results. In their validation study of the SCIBI, Willems et al. (2010) found that higher levels of proactive thinking (subscale of the SCIBI) were indeed positively associated with more experience and with higher educational level.

Overall, SFC can be a useful approach to build useful relationships (Lloyd & Dallos, 2006, 2008). Statistically significant improvement of the QOR was found in seven out of the 13 teams, directly after SFC and at follow-up. QOR also measures "closeness," "conflict," and "dependency." It showed that of these variables, "conflict" changed the most: seven out of the 13 teams after SFC and nine out of the 13 teams at follow-up. This was followed by "closeness" in two out of the 13 teams after SFC and at follow-up, and "dependency" in 0 out of the 13 teams both after SFC and at follow-up. It is plausible that the progress in QOR scores mainly was due to progress in reducing conflicts, and somewhat weakened by lack of progress regarding dependency and closeness. The procedure and collaboration was predominantly evaluated positive by all teams (scores of 9 and higher).

The present study has some limitations concerning the design and the choice and kind of measurement instruments. We only studied an experimental group by comparing measurements taken directly before SFC, after session 3 of SFC, and during follow-up. Without data from control groups to compare, it cannot be confirmed that the teams' goals would have been reached without SFC. In addition, the teams applied for SFC themselves, indicating that they wished to change their current situation. They therefore can be regarded as selective. The small number of research subjects limits generalizations of the findings for other teams. Nevertheless, positive outcomes of this case series do give indications about the possible effectiveness of SFC.

Any choice of standardized measurement instruments automatically implies restrictions. During SFC, every team formulated its own goal. It is possible that the chosen team goal did not sufficiently match the measuring pretention of the instruments being used. This however does not count for the SQP, because this measurement adjusts itself to the goal of the team. This problem of matching measuring pretentions however is true, for example, for the STRS, because the dimensions, closeness, conflict, dependency, and QOR of this instrument could differ from what staff members found relevant to measure. The use of several instruments simultaneously can partly, although not completely, solve this problem. Moreover, all instruments used were self-report instruments and thus reflect the staff members' opinions. Future research could also focus on staff reports verified by observation.

Our findings are in line with results of earlier research on the value of SFBT applied to carers (parents or professionals) of people with ID. Lloyd and Dallos (2006, 2008), for example,

reported that some SFC components like control, choice, and conversations about resilience, coping, and skills may enhance the sense of self-efficacy and proactive thinking in caregivers. Self-efficacy is the idea that someone can influence a desired outcome himself or herself by behaving in a certain way (Bannink, 2009). Proactive thinking is the tendency to initiate change rather than react to events (Kirby & Kirby, 2006). In the present study, nine out of the 13 teams reached the goals that they specified as desirable, and six out of the 10 teams increased proactive thinking at follow-up. Because reaching the goal was based on ideas from staff members about existing skills and earlier successes, it is possible that the expectations of the staff member's own effectiveness (self-efficacy) and the tendency to take action (proactive thinking) will increase. Other researchers emphasized that SFC can lead to relationships between staff and people with ID that are more positive. For example, Wheeler (2001) suggested that SFC alters negative perceptions, interrupts a pattern of blame, and enhances positive attachment. Stoddart et al. (2001) perceived that staff members were influenced by the solution-focused interventions. They began to see more positively the resources, strengths, and characteristics of the people with ID. Also in the present study, SFC seemed to contribute to changes in the perception of people with ID by the staff, possibly resulting in better relationships (more closeness in two out of the 13 teams at follow-up and less conflict in nine out of the 13 teams at follow-up). No decreases were seen in dependency scores. A possible explanation is that the relationship of dimension dependency in people with ID, who need lifelong support from the staff, is less changeable than the dimensions of closeness and conflict.

Future investigation of SFC, preferably using a randomized controlled design, could test the hypothesis that SFC increases self-efficacy and proactive thinking in teams, positively alters staff's perceptions of people with ID, and is considered as a useful approach by teams as well. As a substantial amount of teams that support people with severe to moderate ID experience difficulties in supporting these people, it is fruitful to look for ways to solve these difficulties. In the former times, the tendency was to mainly focus on people with ID as being the one and only cause of support problems, thereby ignoring the role of the staff in these relationships. SFC on the contrary, also focuses on the important role of the staff. Further exploration of the usefulness of SFC is meaningful. Special attention can be paid to the influence of characteristics of teams (e.g., methods of working, internal differences) and/or staff members (e.g., level of education, job satisfaction, and years of experience) on the level of progress on goal attainment, proactive thinking, and QOR with clients.

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