

Processes and effects of Solution-Focused Brief Therapy in people with intellectual disabilities: a controlled study

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Abstract

Background Solution-Focused Brief Therapy (SFBT) is a form of behaviour therapy that focuses on evoking desired behaviour rather than on diminishing existing problem behaviour. SFBT has a number of advantages that makes it attractive for use with people who have intellectual disabilities (ID). These advantages include: focus on empowerment for the person, unique intervention strategies for each person based on their particular skills, and recognition of the expert status of the individual identified as the patient resulting in a sense of self-efficacy.

Methods To investigate the effects of SFBT, we conducted a controlled pre- and post-test and follow-up study with 20 people with mild ID (MID) receiving SFBT and 18 people with MID receiving care as usual (CAU). We expected that SFBT could help people with MID with (1) reaching treatment goals; (2) improving quality of life (i.e. psychological and social functioning); (3) reducing maladaptive behaviour; and (4) increasing resilience (autonomy and social optimism).

Results Two of the 20 clients terminated SFBT prematurely. Most clients receiving SFBT (13 of 18 clients) showed clinically relevant progressions (more than two points on a 1 to 10 scale) towards their treatment goals after SFBT and at follow-up, an additional client showed clinically relevant progress (total of 14 of 18 clients). Directly after therapy, the SFBT group performed statistically significantly better than the CAU group on psychological functioning, social functioning, maladaptive behaviour, autonomy and social optimism. The effect sizes of these improvements were medium to large. At 6-week follow-up, the improvements in psychological functioning, social functioning and maladaptive behaviour in the treatment group were still statistically significant compared with CAU, with medium to large effect sizes.

Conclusions Although the study had limitations because of the short follow-up period and the non-random selection of participants, the statistically significant differences between the SFBT and CAU groups and the medium to large effect sizes, indicate the potential effectiveness of SFBT for people with MID.

Keywords behaviour therapy, intellectual disabilities, Solution-Focused Brief Therapy, therapy effect research

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Introduction

Psychological problems frequently occur in people with intellectual disabilities (ID). Compared with the general population, people with ID are reported to experience behaviour problems and/or psychiatric disorders twice as often (Cooper *et al.* 2007). Recent research and clinical practice experience reports have shown that clients with ID can benefit from individual, couple, family and group psychotherapy. For example, Beail *et al.* (2005) posited that psychotherapy is effective for people with ID, and demonstrated reduced psychological distress and interpersonal problems as well as increased self-esteem.

One approach used in psychotherapy, Solution-Focused Brief Therapy (SFBT; De Shazer 1985), has gained popularity over the past 25 years. SFBT is a short-term, goal-focused and client-directed therapeutic approach that helps clients focus on solutions rather than on problems. In SFBT, the client is considered an expert with regard to his or her own situation. One of the central premises is that the goal of the therapy is defined by the client and that he or she has the competences and resources to realise this goal. The therapist is an expert in asking solution-focused questions that stimulate the client to formulate his or her goal. 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. The therapist encourages the client to describe progression towards the therapy goal in small, specific, behavioural steps. The therapist also suggests tasks such as 'continue with what is already working' in order to stimulate or maintain changes. At the start, variations in the relationship with the client (i.e. whether it is a visitor, complainant or customer relationship) are identified. In a visitor relationship, the client is referred to the therapist by others, has not voluntarily sought help and is not experiencing emotional difficulties. In a complainant relationship, the client is experiencing emotional difficulties, but does not (yet) see him- or herself as part of the problem and/or the solution. In a customer relationship, the client does see him- or herself as part of the problem and/or solution and is motivated to change his or her behaviour. Each type of relationship requires different approaches by the

solution-focused therapist towards the client. For example, in the visitor relationship the therapist may ask what the client thinks the person who referred would like to see changed in his or her behaviour and to what extent the client is prepared to co-operate. In the complainant relationship, the therapist acknowledges the client's difficulties and gives suggestions for observing the moments when the problem is or was present to a lesser extent. In the customer relationship, the client may be given a behaviour assignment (e.g. 'continue with what is already working'). More information about SFBT is given in the treatment protocol in the Method section.

Two meta-analyses reports have reviewed SFBT outcomes in the general population across a wide range of studies. Stams *et al.* (2006) conducted a meta-analysis of 21 studies investigating the effects of SFBT, using Cohen's *d* to measure effect sizes. This meta-analysis found an overall small effect size for SFBT (Cohen's $d = 0.37$; 95% confidence interval: $0.19 < d < 0.55$, $P < 0.001$). Studies that compared SFBT with 'no treatment' ($n = 4$) yielded a medium effect size of Cohen's *d* ($d = 0.57$; $P < 0.01$). Studies that compared SFBT with other treatments ($n = 7$) yielded a small effect size that was not statistically significant of Cohen's *d* ($d = 0.16$; not significant). Kim (2008) conducted a second meta-analysis examining the effectiveness of SFBT (22 comparison group studies) for different types of outcomes: externalising behaviour problems, internalising behaviour problems and family or relationship problems. This meta-analysis found small but positive treatment effects favouring the SFBT groups. However, only the overall weighted mean effect size for internalising problems, such as depression, anxiety, self-concept and self-esteem, was statistically significant at the $P < 0.05$ level, indicating that the treatment effect of the SFBT groups was better than that of the control groups. SFBT appeared to be less effective with externalising behaviour problems such as hyperactivity, conduct problems, aggression, and family and relationship problems. In a review of SFBT outcome research Gingerich *et al.* (2012) stated: 'SFBT is as good or slightly better than other accepted treatments, but it is clearly better than no treatment at all' (p. 106).

Solution-Focused Brief Therapy has a number of advantages that makes it attractive for use in people

with ID. These include a focus on the person's empowerment and 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 *et al.* 2009). In addition, MacDonald (2007) found no statistically significant differences in the effects of SFBT between socioeconomic groups. This is an important finding, as all other psychotherapies are more effective for clients from higher socioeconomic groups (Meyers & Auld 2006), whereas individuals with ID often belong to the lower socioeconomic segments of the community.

To improve the applicability of SFBT for people with ID, several authors have suggested modifications to SFBT as originally described by De Shazer (1985). 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 transpires during the sessions. Also advantageous is using visual aids such as emoticons and drawings, involving carers and family, encouraging and explaining tasks, and adapting task assignments (Teall 2000; Stoddart *et al.* 2001; Corcoran 2002; Lentham 2002; Murphy & Davis 2005; Smith 2005, 2006; Westra & Bannink 2006a, 2006b; Roeden & Bannink 2007; Roeden *et al.* 2009).

Several process studies found that SFBT techniques increase clients' resilience, optimism and self-control (Beyebach *et al.* 1996; Shilts *et al.* 1997; Corcoran & Ivery 2004; Quick & Gizzo 2007). For example, Quick & Gizzo (2007) interviewed 108 clients who were receiving SFBT. The clients credited the therapy model with making them more optimistic and resilient. By the end of the last session, they felt statistically significantly more in control of the problems for which they had sought SFBT. Research literature on the effects of SFBT in people with ID is scarce, but the available literature reveals some promising positive treatment effects. Stoddart *et al.* (2001) 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). Roeden *et al.* (2011) undertook 10 case studies of applications of SFBT in people with mild ID (MID). It was found that SFBT treatments contributed to improved psychological functioning and decreased maladaptive behaviour. In addition, goal attainment was reported by both people with MID and their carers. The positive changes evident shortly after SFBT proved sustainable during follow-up. Both studies, however, are subject to limitations because of the lack of control groups, which means it is possible that the treatment effects could have been reached without SFBT as well.

More research is clearly needed regarding the effects of SFBT in this population. Thus, we conducted a controlled pre- and post-test study with 20 people with MID receiving SFBT and 18 people with MID receiving care as usual (CAU). We expected that SFBT could help people with MID in (1) reaching treatment goals; (2) improving quality of life; (3) reducing maladaptive behaviour; and (4) increasing resilience. We therefore investigated differences in these variables in both groups (SFBT and CAU) at several points in time: before starting SFBT, directly after SFBT and 6 weeks after SFBT.

The key questions in this study were: 'To what extent do clients in the SFBT group reach their treatment goals, and to what extent does the SFBT group outperform the CAU group with regard to improved quality of life, reduced maladaptive behaviour and increased resilience?'

Methods

Participants and procedure

The study was conducted at the programme sites of a service provider for children and adults with ID of all levels (serving approximately 900 people) in the Netherlands. People registered with this provider use various services, such as residential services, day care and home care. This service provider supports approximately 120 clients with MID.

The provider employs qualified psychological therapists and offers SFBT adapted for clients with

MID. The 38 study participants were referred for SFBT by their staff, as all were experiencing problems that warranted change. All these clients had been screened as having clinically significant maladaptive behaviour using the Reiss Screen for Maladaptive Behaviour (RSMB, Reiss 1988). The inclusion criteria for participation were as follows: (1) aged between 18 and 60 years of age; (2) IQ between 50 and 70; and (3) sum scores on the RSMB higher than 7 (see Measures section), indicating the presence of maladaptive behaviour. Exclusion criteria were (1) the presence of acute and severe psychiatric conditions (e.g. psychosis, major depression or bipolar disorder, schizophrenia or suicide risk); and (2) a referral problem that required long-term multidisciplinary intervention (e.g. the treatment of anorexia nervosa). All participants ($n = 38$) lived semi-independently and received individual support (ranging from 2 to 14 h per week) from staff employed by the service provider mentioned above. 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 in the study had MID determined on the basis of IQ, tested by means of the Wechsler Intelligence Scale for Children-III (WISC-III-NL) (Wechsler 2005a) or the Wechsler Intelligence Scale for Adults-III (WAIS-III-NL) (Wechsler 2005b). Their adaptive functioning was tested by means of the SRZ-plus (a Dutch adaptive behaviour scale for people with ID, Kraijer & Kema 1994).

Twenty participants received solution-focused sessions and 18 controls received CAU. Both groups were assessed three times: at pretest, post-test and follow-up (see below). As it was considered unethical to withhold a potentially effective treatment from those who might benefit from SFBT, all clients in the CAU were placed on a waiting list for SFBT, with the assurance to offer them SFBT as soon as there were vacancies. Twenty clients who were experiencing problems that warranted change were recruited into the study and started on SFBT over the course of 1 year. At the start of year 2, the next 18 clients were recruited and assessed three times as the SFBT group, before commencing SFBT. For both groups, data collection was more or less spread over

the entire year, depending of the date clients enrolled in the study.

Care as usual is most dissimilar to SFBT in terms of the role of staff. As applied in the setting mentioned above, CAU is a type of coaching that focuses on the problem-solving model. In this model, the description of client problems and the formulation of client goals, as well as the coaching plan and interventions are all primarily performed by staff. In CAU staff suggest or prescribe the solutions, serving as the experts who advise clients on the actions to take to alleviate their problems.

In both conditions, three data measurements were taken: the first immediately before SFBT; the second immediately after SFBT and the third, a follow-up measurement, 6 weeks after SFBT. Three measurements were also taken in the CAU group: the first baseline measurement; the second measurement after 15 weeks (the mean length of all SFBT treatments) and the third, a follow-up measurement after $15 + 6 = 21$ weeks. The two solution-focused therapists in this study had a master's degrees in behaviour therapy. Their additional training programme on SFBT included the history and philosophy of SFBT, the tenets of SFBT, the session format and structure of SFBT, video examples from the developers of SFBT, role playing and supervised practice using SFBT with clients with ID.

All participants agreed to participate in the study and provided permission for anonymous publication of the study data. Permission for the study was given by the Client Council (composed of clients with ID) and by the organisation's Client Representative Council (comprising family members or other representatives of people with ID) to ensure client rights. Both councils acknowledged that the research proposal corresponded to guidelines for carrying out research projects involving people with ID in the Netherlands.

Solution-Focused Brief Therapy protocol

Every SFBT session was attended by at least three people: the person with MID, a staff member and the therapist. In the application of SFBT, every person with MID was accompanied by a personal carer who knew the client well. Experiences with SFBT have shown that the interventions are better understood and executed when carers perform a

supportive role in the treatment procedure (Teall 2000; Stoddart *et al.* 2001; Roeden & Bannink 2007). The client was accompanied by the same personal carer during all SFBT sessions rather than involving multiple carers. Each participant with ID consented to the presence of the staff member. The treatment protocol consisted of six meetings: (1) intake; (2) first session; and (3) four subsequent sessions. Every treatment had the same format, much of which is taken from De Shazer *et al.* (2007). A follow-up meeting was provided to obtain post-treatment measurements, including goal attainment.

Intake

'Getting acquainted': First the therapist spends time getting to know the client. Competences and resources are explored, and the overall attitude is positive, respectful and hopeful. 'Exploring the problem': During this same intake session, the therapist invites the client to describe his or her problem and/or to indicate his or her goal for the treatment. The therapist acknowledges the problem, which confirms to the client that the therapist is not underestimating the seriousness of the problem.

First session

'Pre-session change': As most clients have tried other strategies before meeting with a therapist, the therapist asks about any changes that have already been made before the first session. 'Goal-setting': The client is invited to describe what would be different once his/her goal is reached. All the goal-directed questions are framed using the future tense for example by means of the 'miracle question': 'Imagine a miracle occurring tonight that would (sufficiently) solve the problem. What would be different tomorrow?'. The therapist tries to elicit smaller goals rather than larger ones. Clients are encouraged to frame their goal as the presence of a solution rather than the absence of a problem, by means of the question: 'What do you want to see happening instead of the problem?'. 'Exploring the exceptions': There is a discussion about those times when the problem does not occur or is less of a problem. 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': On a

scale of 1–10, the client indicates his or her progression towards the goal. Scaling questions help the client to move away from all-or-nothing goals towards manageable and measurable steps.

'Competence questions': The use of competence questions encourages self-compliments by the client. 'How do (did) you do that?'. 'Resilience or coping questions': Most people have previously solved many problems. The therapist therefore may ask: 'How do (did) you manage to go on under such difficult circumstances?' or 'This sounds hard, how are you managing to cope with this?'. 'Feedback': Each session ends with feedback, usually involving compliments for each person present and suggestions for a task. The suggestions indicate areas requiring the client's attention ('observation task') or possible further actions ('behaviour task') to reach his or her goal, such as 'think or observe what in your present life you want to keep the same' or 'pretend on one day each week that the miracle has happened'.

Subsequent sessions

In the subsequent sessions the therapist uses the 'EARS question set'. EARS is an acronym for Eliciting, Amplifying, Reinforcing and Start again, and outlines the therapeutic process (Bannink 2010). The first question is: 'What is better?'. The individual can respond in three different ways: 'It is better', 'There is no change' or 'It is worse'. If the situation is better, the therapist can respond by amplifying ('What exactly is (somewhat) better?'), reinforcing ('How did you manage to do that?') and starting again ['What (else) is better?']. EARS can also be used if the person thinks there is no change. The therapist acknowledges the client's potential, emphasises that keeping things stable is also a good accomplishment, and asks the individual to explain how he or she managed to keep things stable. If the situation is worsening and the person with MID is disappointed, the therapist also acknowledges this. A reorientation to the goal may be necessary or the therapist could ask the person resilience questions, which may offer re-entry to the EARS questions. 'Consolidation questions' are used at the end of the therapy to increase the likelihood that the client will keep on working towards the desired goal, e.g. 'What do you have to do to make sure that these results keep happening?'.

As stated in the earlier section entitled SFBT protocol, the clients were accompanied by a staff member who supported them during the SFBT trajectory. The measurements (in both the SBT and the CAU conditions) were performed by the therapists/researchers. If necessary, the staff member assisted the client to understand the questions from the therapists/researchers by repeating the words or slightly reformulating them. In addition, staff members assisted by making the client's answers clear to the therapists/researchers by repeating the words of the client. Following Teall (2000) and Smith (2006), we reasoned that help from a familiar person in answering questions and interviewing by a certified professional (the therapist/researcher) would lead to more valid responses.

Measures

Goal attainment was only measured in the SFBT group. Differences with regard to quality of the life, maladaptive behaviour and resilience were measured in both groups (SFBT and CAU). The Scaling Question Progression (SQP) uses a scale of 1 (*goal not reached*) to 10 (*goal reached*) on which the client indicates to what extent s/he has approached or has reached her/his therapeutic treatment goal (Bannink 2010). In a study by Fischer (2009), the individual scale question was used with 3920 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 points for emotional coping. In this study, a progression of +2.0 points (being relatively high) was considered clinically relevant.

The Intellectual Disability Quality of Life (IDQOL-16; Hoekman *et al.* 2001) was used to measure the client's quality of life. The IDQOL-16 has three sub-scales: psychological functioning, social functioning and satisfaction about housing. Sum scores are indications of an individual's perceived quality of life. The 'satisfaction with housing' sub-scale was not included in the treatment results because housing satisfaction is not a primary goal of SFBT. The IDQOL-16 has been shown to have good internal consistency (Cronbach's α of the various sub-scales were between 0.73 and 0.80).

Each question has five response categories ranging from *very unpleasant* to *very pleasant*, indicated by a pictogram (smiley).

In the IDQOL, the raw scores on the sub-scales can be transformed into quartile scores (rating of 1–4). Higher quartiles are indicative of higher satisfaction. The ranges of these quartiles are presented in Table 2.

The RSMB (Reiss *et al.* 1994) was used to measure maladaptive behaviour. The RSMB measures the presence of psychological problems and was completed by a staff member who had knowledge of the person concerned. The list of questions was comprised of nine subdivisions: aggression, autism, psychosis, depression (behaviour symptoms), depression (vital symptoms), paranoia, dependent personality disorder, avoidant disorder and 'other maladaptive behaviour'. The internal consistency of the nine subdivisions ranged from reasonable to good (Cronbach's α ranged between 0.69 and 0.87). Stability was calculated only for the total score and was found to be good (Pearson's $r = 0.81$). The inter-rater reliability for the subdivisions was reasonable to good (Pearson's r ranged between 0.50 and 0.84). The staff evaluated each behaviour item as to whether it was *no problem* (zero points), *a problem* (one point) or *a big problem* (two points) for each person. The sum score of the RSMB is a general indication of the level of maladaptive behaviour displayed by an individual with ID. Normative information for adults with ID is provided in the original RSMB manual by Reiss (1988). For the subpopulation of clients with MID, sum scores higher than 7 indicate the presence of maladaptive behaviour (Dutch norms, Reiss *et al.* 1994) and are considered to be a threshold for clinically significant problems.

The Positive Outcome Scale (POS; Appelo 2005) is a 10-item self-report instrument that assesses resilience by providing seven items on autonomy and three on social optimism. Sum scores are indications of an individual's perceived resilience. The reliability (Cronbach's α : 0.88), test-retest reliability (Pearson's $r = 0.71$ and 0.77 for the two sub-scales) and validity (correlations of about 0.60 with different measures for self-efficacy) proved to be sufficient (Appelo 2005). Each question has four response categories ranging from 1 = *completely untrue* to 4 = *completely true*. The POS manual

provides scores for 'policlinic, low-educated people with psychopathology'. Table 2 shows the ranges of these scores for both sub-scales.

Reasons for dropout from the study

In this study, dropout was defined as 'any termination of the treatment by the client before the fifth SFBT-session'. Within 3 days of termination, dropout clients were asked to rate a series of 10 explanations for dropping out, using a dichotomous (yes/no) response format. The explanations included: (1) there was insufficient progress in the treatment; (2) trust in the treatment was gone; (3) the treatment was too difficult; (4) the approach did not allow for enough freedom; (5) the treatment was stopped as a result of pressure by family or partner; (6) the treatment was stopped as a result of conflict or disagreement with the staff; (7) the treatment was not a personal choice; (8) the treatment jeopardised school, work, or spare time; (9) the treatment was stopped because of a bad or disappointing working relationship with the therapist; and (10) the treatment did not cover useful therapy goals.

Statistical analyses

Statistical analyses were used to test for changes in scores on the IDQOL, RSMB and POS of both groups over time. Given the relatively small sample sizes (SFBT: 18 clients; CAU: 18 clients, two dropouts) non-parametric tests (the Wilcoxon signed-rank test and Mann-Whitney test) were used to analyse the data rather than parametric tests. The Wilcoxon test was used to investigate differences within the SFBT group and within the CAU group. The changes in scores on the IDQOL-16, RSMB and POS before SFBT and after SFBT, and before SFBT and at follow-up, were analysed for statistical significance. The direction of the difference (positive or negative change) was calculated using the Sign test. The Mann-Whitney test was used to investigate differences between the SFBT group versus the CAU group. The non-parametric tests were performed on the key variables of goal attainment (via SQP), quality of life (i.e. psychological functioning, social functioning; via IDQOL-16), maladaptive behaviour (via RSMB, and resilience (i.e. autonomy and social optimism; via POS). 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: $p/n = 0.05/5 = 0.01$. Scaling (SQP) is not an intervention in CAU, thus no SQP data were available for the CAU group. Additionally, the number of clients in both groups who showed improvements on the outcome measurements are given.

Effect size

Effect size is an objective and standardised measure of the magnitude of observed effects (Field 2009). The American Psychological Association recommends the use of effect size in the results of any published work. Pearson's correlations coefficient *r* can be used as an effect size measure, lying between 0 (*no effect*) and 1 (*perfect effect*). The equation to convert a non-parametric *z*-score into the effect size, *r*, is $r = z/\sqrt{N}$ (Field 2009, p. 550 and p. 558) in which *z* is the *z*-score of the Wilcoxon or Mann-Whitney test and *N* is the number of observations. The criteria established by Cohen (1988) were used to interpret effect sizes: no effect, $r < 0.10$; small effect, $r \geq 0.10$ and < 0.30 (1–9% of the total variance); medium effect, $r \geq 0.30$ and < 0.50 (9–25% of the total variance); and large effect, $r \geq 0.50$ (>25% of the total variance). We regarded the effect of SFBT as substantial only when (1) the differences in scores between SFBT and CAU were statistically significant ($P \leq 0.01$, Dunn-Bonferroni correction) and (2) the effect size was at least medium ($r \geq 0.30$).

Results

A total of 20 clients received SFBT. Eighteen clients completed the therapy and two dropped out of treatment (see 'Reasons for dropout' below). These dropouts did not complete the measurements directly after SFBT or at follow-up. Eighteen clients received CAU. To rule out possible initial differences, the two groups were compared for age, IQ and adaptive functioning. No statistically significant differences were found between these characteristics (see Table 1). Moreover, no statistically significant differences were found between the SFBT ($n = 18$, excluding two dropouts) and the CAU group with

Table 1 SFBT and CAU groups according to sample size (absolute numbers), dropouts, age, IQ, adaptive and maladaptive functioning (means and SDs)

Characteristics	Study group		Comparison data Mann-Whitney test*
	SFBT	CAU	
Sample size	<i>n</i> = 20	<i>n</i> = 18	
Dropout	<i>n</i> = 2	–	
Age	43.4 (SD = 16.4)	41.5 (SD = 12.6)	<i>z</i> = –0.1, <i>P</i> = 0.92
IQ	61.3 (SD = 6.4)	62.9 (SD = 4.9)	<i>z</i> = 0.8, <i>P</i> = 0.44
Adaptive functioning [†]	6.6 (SD = 0.8)	6.9 (SD = 0.8)	<i>z</i> = 1.1, <i>P</i> = 0.27

* Measured by the WISC or WAIS IQ test (see Method section).

[†] Measured by the SRZ-plus questionnaire (see Method section).

SFBT, Solution-Focused Brief Therapy; CAU, care as usual; WISC, Wechsler Intelligence Scale for Children; WAIS, Wechsler Intelligence Scale for Adults.

regard to pre-treatment mean scores of relevant measurements: IDQOL-16 [SFBT: 57.7 (SD = 6.7) versus CAU: 61.4 (SD = 7.4); *z* = –1.6, *P* = 0.11], RSMB [SFBT: 11.6 (SD = 7.4) versus CAU: 9.6 (SD = 8.6), *z* = –1.1; *P* = 0.26] and POS [SFBT: 29.3 (SD = 3.7) versus CAU: 29.5 (SD = 3.3); *z* = –0.10, *P* = 0.93].

Two clients dropped out of treatment for different reasons, which they indicated on the dropout list within 3 days of discharge. The first client reported the following two reasons for dropping out: (1) trust in the treatment was gone and (2) the treatment was stopped because of a disappointing working relationship with the therapist. The second client also gave two reasons: (1) the treatment was stopped as a result of pressure by the family or partner and (2) the treatment was not a personal choice. Both clients were asked, but chose not to fill in the IDQOL and POS questionnaires, leaving data from 18 SFBT clients for the statistical analyses.

Goal attainment (or progression towards the goal) was measured by using the SQP. No SQP data were available for the CAU group, as no goals were formulated in CAU. During the intakes, the following problems were reported by the participants and/or their staff in the SFBT group: alcohol abuse (three clients), anger (two clients), bereavement (two clients), depression/apathy (two clients), sleeplessness (one client), low self-esteem (three clients), avoidance/anxiety (one client), couples conflict (two

clients) and self-help issues (two clients). The two dropouts reported problems with being in public places and being inactive in social relationships. During the first session, all clients formulated treatment goals, prompted by the solution-focused key question: ‘What do you want to see instead of the problem?’. This led to the following goals addressing the problems mentioned above: alcohol control (three clients), anger management (two clients), coping with bereavement (two clients), happiness/initiative (two clients), a good night’s sleep (one client), self-confidence (three clients), courage (one client), a good relationship (two clients) and mastering self-help or aspects thereof (two clients).

Thirteen of 18 clients showed progressions of two points or more on the SQP after SFBT, as did 14 of 18 clients at follow-up. The differences in the scores of the 18 clients were statistically significantly higher after SFBT (mean progression +2.2 points; *z* = –3.8; *P* < 0.01) and at follow-up (mean progression +2.4 points; *z* = –3.7; *P* < 0.01). The remaining clients showed less improvements on the SQP (after SFBT, one client +0.5 point and four clients +1 point; at follow-up, one client zero points and three clients +1 point).

Differences within groups

The differences in scores for both the SFBT and CAU groups for all measurements are presented in Table 2. At the start of the study, both groups had

Table 2 Within-group differences (SFBT and CAU) in psychological and social functioning (IDQOL), maladaptive behaviour (RSMB), autonomy and social optimism (POS) of the before, after and follow-up measurements and mean changes

Measurement	n	Group	Before Mean	After Mean	Mean change before vs. after; Signed-rank test Effect size [†]	n	Follow-up Mean	Mean change before vs. follow-up; Signed-rank test Effect size	
IDQOL Psychological functioning	18	SFBT	16.4	19.9	+3.5	16	20.1	+3.7	
			16/18 [§]		$z = -3.6, P < 0.01$; $r = 0.60$, large [¶]				13/16 [§]
	1th quartile: [‡] [5–19]								
	2nd quartile: [20–21]								
IDQOL Social functioning	18	CAU	18.0	17.7	-0.3	16	18.6	+0.6	
			8/18		$z = -0.4, P = 0.71$ $r = 0.07$, no effect				9/16
	3rd quartile: [22–24]								
	4th quartile: [25≥]								
IDQOL Social functioning	18	SFBT	21.9	23.3	+1.4	16 [‡]	24.3	+2.4	
			11/18		$z = -2.0, P = 0.04$ $r = 0.33$, medium				11/16
	1th quartile: [‡] [6–24]								
	2nd quartile: [25–26]								
IDQOL Social functioning	18	CAU	24.1	23.3	-0.8	16	24.3	+0.2	
			3/18		$z = -1.7, P = 0.10$ $r = 0.28$, small				3/16
	3rd quartile: [27–29]								
	4th quartile: [30≥]								
RSMB Maladaptive behaviour	18	SFBT	11.6	5.9	-5.7	18	6.7	-4.9	
			18/18 [§]		$z = -3.7, P < 0.01$ $r = 0.62$, large [¶]		16/18 [§]	$z = -3.4, P < 0.01$; $r = 0.57$, large [¶]	
RSMB Maladaptive behaviour	18	CAU	9.6	8.3	-1.3	18	8.9	-0.7	
			10/18		$z = -1.4, P = 0.16$ $r = 0.23$, small		8/18	$z = 0.0, P = 0.97$; $r = 0.00$, no effect	
POS Autonomy	14 ^{**}	SFBT	19.8	22.3	+2.5	14	22.1	+2.3	
			11/14 [§]		$z = -2.9, P < 0.01$ $r = 0.55$, large [¶]				10/14 [§]
	Range for policlinic low-educated people: [15–23]								
	POS Autonomy	18	CAU	19.6	20.1	+0.5	16	20.7	+1.1
5/18					$z = -0.9, P = 0.36$ $r = 0.15$, small	7/16			
POS Social optimism	14	SFBT	9.5	10.5	+1.0	14	10.6	+1.1	
			8/14 [§]		$z = -2.6, P = 0.01$ $r = 0.49$, medium [¶]				9/14
	Range: Range for policlinic low-educated people: [7–11]								
	POS Social optimism	18	CAU	9.9	9.7	-0.2	16	9.8	-0.1
3/18					$z = -1.3, P = 0.37$ $r = 0.22$, small	2/16			

* Ratio: number of clients who changed in the desired direction/total number of participants.

[†] Effect sizes: no effect, $r < 0.10$; a small effect, $r \geq 0.10$ and < 0.30 ; a medium effect, $r \geq 0.30$ and < 0.50 and a large effect, $r \geq 0.50$.

[‡] Quartile scores of sub-scales.

[§] Number of client with positive changes

[¶] Differences over time within groups are statistically significant ($P \leq 0.01$) on the Wilcoxon test and the effect size is at least 'medium'.

** Lower sample sizes because of missing values.

SFBT, Solution-Focused Brief Therapy; CAU, care as usual; IDQOL, Intellectual Disability Quality of Life; RSMB, Reiss Screen for Maladaptive Behaviour; POS, Positive Outcome Scale.

average scores in the lowest quartiles of the quality of life measures, indicating low satisfaction ratings on psychological and social functioning. The initial average resilience scores of both groups also fell

within the lower ('poli-clinic') ranges. Before SFBT, the problems reported in both the SFBT group and the CAU group fell within the clinically significant range (average scores for maladaptive behaviour

Table 3 Between-group differences (SFBT versus CAU) in psychological and social functioning (IDQOL), maladaptive behaviour (RSMB), autonomy and social optimism (POS) of the before, after and follow-up; number of clients and mean changes

Measurement		n	Group	Mean change after SFBT	Mann-Whitney test Effect size*	n	Mean change at follow-up	Mann-Whitney test Effect size
IDQOL	Psychological functioning	18	SFBT	+3.5	$z = -3.7, P < 0.01$	16 [†]	+3.7	$z = -2.7, P < 0.01$
		18	CAU	-0.8	$r = 0.62, \text{large}^\ddagger$	16	+0.6	$r = 0.48, \text{medium}^\ddagger$
	Social functioning	18	SFBT	+1.4	$z = -2.6, P = 0.01$	16	+2.4	$z = -2.6, P < 0.01$
		18	CAU	-0.6	$r = 0.43, \text{medium}^\ddagger$	16	+0.2	$r = 0.46, \text{medium}^\ddagger$
RSMB	Maladaptive behaviour	18	SFBT	-5.7	$z = -3.5, P < 0.01$	18	-4.9	$z = -3.3, P < 0.01$
		18	CAU	-1.3	$r = 0.58, \text{large}^\ddagger$	18	-0.7	$r = 0.55, \text{large}^*$
POS	Autonomy	14 [†]	SFBT	+2.5	$z = -2.7, P < 0.01$	14	+2.3	$z = -1.3, P = 0.19$
		18	CAU	+0.5	$r = 0.48, \text{medium}^\ddagger$	16	+1.1	$r = 0.24, \text{small}$
	Social optimism	14	SFBT	+1.0	$z = -2.9, P < 0.01$	14	+1.1	$z = -2.0, P = 0.05$
		18	CAU	-0.2	$r = 0.51, \text{large}^\ddagger$	16	-0.1	$r = 0.37, \text{medium}$

* Effect sizes: no effect, $r < 0.10$; a small effect, $r \geq 0.10$ and < 0.30 ; a medium effect, $r \geq 0.30$ and < 0.50 and a large effect, $r \geq 0.50$.

[†] Lower sample sizes because of missing values.

[‡] Differences over time between groups are statistically significant ($P \leq 0.01$) on the Mann-Whitney test after SFBT and the effect size is at least 'medium'.

SFBT, Solution-Focused Brief Therapy; CAU, care as usual; IDQOL, Intellectual Disability Quality of Life; RSMB, Reiss Screen for Maladaptive Behaviour; POS, Positive Outcome Scale.

11.6 and 9.6 respectively, both higher than the cut-off score of 7).

After SFBT the SFBT group performed better (Wilcoxon test: $P \leq 0.01$), on psychological functioning (IDQOL-16), reduced maladaptive behaviour (RSMB) and autonomy (POS). After SFBT, positive changes were evident in 16 of the 18 clients for psychological functioning, in 11 of 18 clients for social functioning, in all clients for reduced maladaptive behaviour, in 11 of 14 clients for autonomy, and in 8 of 14 clients for social optimism (Sign test: $P < 0.01$ for all measures). In contrast to the CAU group, the mean maladaptive scores receiving SFBT dropped even below the threshold of seven points after SFBT and at follow-up. Albeit that at group level no statistical significant differences were seen in the CAU group (Wilcoxon test: $P > 0.05$), some clients in the CAU group showed positive changes in psychological functioning, social functioning, reduced maladaptive behaviour, autonomy and social optimism (after SFBT measurement), respectively, 8, 3, 10, 5, 3 (of 18 clients). The same was true for measurements at follow-up (improvement in respectively 9/16, 3/16, 8/18, 7/16, 2/16 clients).

At follow-up, the improvements in psychological functioning, reduced maladaptive behaviour, autonomy were sustained in the SFBT group (in 13 of 16, 16 of 18 and 10 of 14 clients respectively; Sign test: $P < 0.01$). The effect sizes were at least medium. The changes after SFBT for social optimism were positive in 8/14 clients and just reached statistical significance at group level ($P = 0.01$), but did not at follow-up ($P = 0.07$ at group level; at individual level, 9/14 clients showed positive changes).

Changes in social functioning after SFBT and at follow-up did not reach statistical significance in the SFBT group ($P = 0.04$), although there were medium effect sizes. There were no statistically significant changes in social functioning and social optimism in the CAU group ($P > 0.05$).

Differences between groups

The key issue in this study is whether or not the changes in scores between the measurements differ between the SFBT group and the CAU group.

Table 3 shows the results of these analyses. Not all

clients completed all questionnaires in full: the exact number of respondents is given in the relevant tables. For this reason, the pairs of observations differed to some extent within and between groups in Tables 2 and 3. The analyses revealed that the SFBT group performed better than the CAU group directly after SFBT with regard to all key variables: psychological functioning, social functioning, maladaptive behaviour, autonomy and social optimism (differences between groups for all variables $P < 0.01$). The effect sizes were large, medium, large, medium and large respectively. At follow-up, the differences were no longer statistically significant for autonomy and social optimism ($P = 0.19$ and $P = 0.05$ respectively). However, the results were sustained at follow-up for psychological functioning, social functioning and maladaptive behaviour ($P < 0.01$). The effect sizes for these three variables were medium, medium and large respectively.

It may be concluded that SFBT offers improved results in the areas of psychological functioning, social functioning and maladaptive behaviour than CAU. The results for autonomy and social optimism (resilience) were not sufficiently sustained at follow-up.

Discussion

The results of this study indicate that SFBT can be considered as a valuable contribution to the support strategies offered to people with MID. Most clients in this study showed clinically relevant progressions (more than two points on a 1–10 scale) towards their treatment goals after SFBT (13 of 18 clients) and at follow-up (14 of 18 clients).

Directly after therapy, the SFBT group showed greater improvements than the CAU group on psychological functioning, social functioning, maladaptive behaviour, autonomy and social optimism. At follow-up, 6 weeks after therapy, the improvements on the first three measures mentioned were sustained. Overall, these results are similar to recent SFBT outcome research in the general population, showing that SFBT is more effective than 'treatment as usual' (MacDonald 2007; Gingerich *et al.* 2012) with medium effect sizes (Stams *et al.* 2006).

This study has some limitations concerning the choice and type of outcomes, the length of the

follow-up period, and the research design. The first issue to consider is that any choice of standardised instruments automatically implies restrictions. During SFBT, each individual formulated his or her own goal. It is possible that the chosen goal did not sufficiently match the measuring presentation of the instruments used. This does not apply to the SQP, because this measurement adjusts itself to the individual's goal. However, it does hold true for the IDQOL and the POS, as the quality of life domains and the resilience domains within these instruments were broad and could differ from what people with MID considered to be relevant outcomes. The fact that SFBT had minimal effect on, for example, social optimism, may confirm this thought. Second, it is difficult to conclude from this study whether the improvements attributed to SFBT can hold over time. Although gains were made through the interventions, it remains uncertain whether these improvements will last over time (e.g. longer than 1 year). Another consideration is that the choice and allocation of participants may be subject to discussion. All SFBT clients were referred by staff and not randomly allocated to both conditions. It is possible that the selected clients tended to be more co-operative in therapy and the outcomes could be more favourable to SFBT compared with a random selection. In future research, the intent will be to recruit more potential participants in a relatively shorter period of time (e.g. by collaboration with other service providers). This would enable researchers the ability to random allocation of participants to the SFBT or CAU group. Change process research can identify how clients can benefit from any particular intervention (McKeel 2012). For example in SFBT, goal setting is an important issue. In future research, it may be of interest to study to what extent this goal setting accounts for the effects, rather than really working on the goals. Additionally, measurements (in both the SBT and the CAU condition) were also administered directly by the therapists/researchers. This meant that the participants and therapists/researchers were not blinded to the treatment condition or the treatment results. Biases due to the non-random allocation of groups and non-blind assessors may have influenced the results and cannot be ruled out.

Despite these limitations, we conclude that SFBT has several strengths and advantages that makes it a useful additional approach for use with people with ID. First, SFBT focuses on skills rather than on deficits, and it recognises the expert status of people with MID. This is in line with the present view of ID that focuses on elements such as the importance of empowerment. Second, our findings support Stoddart *et al.*'s (2001) discussion of the strengths of using SFBT in people with ID: 'SFBT is a highly structured, active and directive approach. It focuses on concrete and immediate issues. The approach partialises problems by setting limited and clearly defined goals, and it fosters an early and positive relationship between clients and therapists' (p. 36). As stated in the introduction, people with ID are reported to experience behaviour problems and/or psychiatric disorders twice as often as the general population (Cooper *et al.* 2007). SFBT can support them in overcoming or at least reducing such problems in a structured and focused manner, emphasising the individual's unique contribution. In this study, we focused on clients with clinically significant problems. However, SFBT can also be used for less severe problems, such as housekeeping issues (see Roeden *et al.* 2009 for the use of SFBT with a less severe problem). Third, SFBT encourages the involvement of staff in the therapeutic process. This may help staff to develop more positive views of people with MID and to become more aware of their resilience, resources and competences, and in particular their ability to come up with solutions themselves (Lloyd & Dallos 2006, 2008). Indeed, solution-focused principles and techniques developed in a therapeutic context can easily be adapted to a staff context. This also implies possibility of using SFBT as tool for non-therapeutic coaching. As in SFBT, staff actually can develop a strengths-based mindset: focusing on solutions rather than problems, on strengths rather than weaknesses, and asking more than telling.

Solution-focused therapists can be seen as specialists who can be employed on a temporary basis to assist clients with MID in achieving their therapy objectives. These temporary contributions become more sustainable if staff works in a solution-focused manner in their everyday practice. This entails adopting a solution-focused attitude by staff and

making use of solution-focused conversation skills in supporting clients. Finally, unlike other therapies, there is empirical evidence that SFBT is equally effective for all socioeconomic groups (MacDonald 2007). People with MID are often economically disadvantaged and usually belong to lower social groups; the finding that they too can benefit from SFBT is certainly encouraging.

We therefore conclude that SFBT can be regarded as a valuable therapy tool. Nevertheless, further research in this area is needed, and should involve randomisation, larger sample sizes, standardised measures, prolonged follow-up measurements and comparisons with other established therapies.

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