

## SOLUTION FOCUSED BRIEF THERAPY (SFBT)

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Solution-focused brief therapy (SFBT) covers the terms solution-oriented work, solution-focused practice, thinking, consultation and coaching. SFBT is described by Sundman, (2012) on behalf of The European Brief Therapy Association (EBTA) as:

- a) Client centred and directed.
- b) Interactional; as the therapists use language carefully to help clients re-construct problems and solutions.
- c) Competency-based; meaning that SFBT focuses on resources, strengths, abilities and successes. It then aims to transform them into skills and competencies.
- d) Future oriented; as it helps the client describe a detailed vision of their preferred future.
- e) Goal-directed.

SFBT is a relatively new and pragmatic therapeutic approach. It was developed largely by de Shazer, (1985, 1988), de Shazer et al (1986), O'Hanlon & Weiner-Davis (1989), their colleagues and their clients at the Milwaukee Brief Family Therapy Centre in the USA the early 1980s. The approach developed from clinical practice process research and user feedback. The developers recorded and observed substantial amounts of therapy, examined the questions asked and clients' responses. The questions that most often led to clients thinking, talking about or reporting solutions and progress were incorporated into the approach. Those that did not were excluded. Hence the therapists and their clients identified the elements of therapy they thought most useful to the client. The therapists did more of 'what worked' and 'less of what didn't work' to develop the approach. This development work continues (e.g. Miller & de Shazer, 2000 and Piercy, Lipchick & Kiser, 2000, De Shazer & Dolan, 2007). Each session is designed so that it can 'stand alone' and be of some value to the client even if he or she only attends once.

Inevitably the original therapists' theoretical and clinical backgrounds influenced the development of SFBT; these included the philosophical ideas of Wittgenstein, the work of Milton Erickson, The Mental Research Institute in Palo Alto, strategic and systemic family therapy and brief narrative therapies. SFBT is considered post-modernist in that it does not try to replace previous models or theories but integrates and builds on them. The SFBT approach makes some assumptions outlined in table 1.

Table 1.

- *Problems and solutions are subject to an individual client's perception and interpretation.*
- *Language constructs and re-constructs both problems and solutions.*
- *The solution is not necessarily related to the problem.*
- *The client's goals are central.*
- *An emphasis on the past, diagnosis and details of the problem are not essential.*
- *There are occasions when problems are less or absent (exceptions).*
- *Practitioners believe that clients can make changes.*
- *Small changes can have an important impact.*
- *Resistance is not a useful concept, clients co-operate in different ways. The clients have expertise on what is helpful and unhelpful.*

The EBTA, (Sundman, 2012) has created a practice definition of SFBT that captures the elements of the intervention and the evolving nature of the approach. It states 'we make no claim of ownership or copyright ..... Solution Focus should remain open for all. We also believe that the Solution Focused Practices will develop further.' To enable research and meaningful comparisons across outcome studies the EBTA (Beyebach 2000) also created a research definition or protocol. This is prescriptive, to a point, as it has minimal requirements and some questions must be asked in a specified format or verbatim. It advocates that a specific therapy model must be used (De Shazer, 1988, 1991, 1994). Common features of SFBT interventions include the following:

1. *Language*: The client's language is used by the therapist. In SFBT language also reflects two important ideas a) problems and solutions are subject to individual's perceptions of them and b) there are times when problems are less intense. In this way

ideas of hope, that problems are transient or have potential to be different or perceived differently are introduced. For example 'I am depressed' may be para-phrased 'you say you feel depressed at the moment' or 'How does depression show itself?'

2. *Exceptions, pre-treatment change and problem-free talk:* The therapist enquires about areas of the person's life that illustrate competence, strength and resources. An interest is taken in steps the client has already taken to address their situation and the therapist is curious about times the problem is absent or less intense. The approach does not ignore problems, adversity or difficulty if the client raises them. An empathic stance is combined with curiosity about resources, coping and resilience e.g. if a client describes adversity the therapist may respond with 'That sounds tough. How have you coped?'

3. *Hypothetical future:* SFBT aims to shift attention to the life the client would like to lead. The client is asked to imagine a desired hypothetical future, to imagine a time beyond their immediate problems. de Shazer (1988) designed the miracle question for this purpose and it is this form of words that is recommended in the EBTA research protocol.

"Suppose that one night when you were asleep there was a miracle and this problem was solved. The miracle occurs while you are sleeping, so you do not immediately know that it has happened. When you wake up what are the first things you will notice that will let you know there has been a miracle?"

In the practice definition the client's vision of his or her preferred future may be elicited in a variety of ways often capitalising on the language the client is already using. The therapist then asks what the client will notice is different and what others might notice about the client. The client then describes a future in which the perception of problems or the problems themselves are less intense. Hypothetical futures sometimes involve others changing and clients are reminded that the miracle happened to them alone.

4. *Rating scales:* Rating scales from 0-10 are created where 10 is the day after the miracle/preferred future. The client positions the present on the scale. Questions follow and the client describes different parts of the scale. The therapist is curious

about how the client got so far, what is preventing him or her sliding backwards on the scale and if there are any times when he or she is at a different point on the scale or what a 0.5 move forward on the scale would look like. Scales may also be used to indicate how confident the client feels in working towards the goal.

5. *Goals*: Goals are elicited from the clients. The goals are small, observable and positive i.e. the presence of behaviour rather than the absence of something.

6. *Breaks, tasks and compliments*: The therapist may take a break to consult with a reflecting team. Compliments are given; usually observations or reflections about exceptions, strengths, resources and motivation. Inter-session tasks often include observing exceptions, experimenting with doing more of what works or doing something different to usual when the problem arises. If the client has not completed the inter-session task the therapist may suggest that the client perhaps wisely prioritised other things in life or that perhaps the client judged that the task or the time were not right.

7. *Closing the session*. The therapist seeks the client's opinion on whether there should be another session, if so how distant in time, where and when.

#### Adaptations to SFBT in learning disability services

SFBT is used in services for people who have intellectual disabilities in a variety of ways. There is face to face work with a therapist and a person who may engage alone or with a parent, paid carer or teacher involved to varying degrees as a supporter. There are also those, often with little or no language, who receive therapy 'by proxy', when a parent or carer seeks help on their behalf or seeks help for themselves as the carer to manage a situation. This is often called solution-focused consultation. Finally there is solution-focused coaching in which SFBT is taught to staff to change interaction styles and thinking within an organisation e.g. a care home. The core assumptions of SFBT and adaptations to the approach for each of these groups are considered along with some notes of caution.

The core assumptions of SFBT described in table 1 do not need to be changed when working with people who have ID. However some beliefs about people who have ID may be challenged by the model. Bliss (2012) reflects on how humbling it is to realise that a client who was previously seen as institutionalised, limited and problematic can be seen as having huge resources and strengths; the resilience to have survived the trauma of long stay institutions whilst remaining cheerful, determined and kind. It raises the question ‘how did that happen?’ which leads to conversations about resilience. Acknowledging the client’s expertise when that client has an intellectual disability may also be a challenge to therapists and support staff but once it is acknowledged true collaboration can occur. Sometimes a therapist can think it is unethical to withhold expertise or wishes the client to make an informed choice. Bliss (2012) advises taking a ‘one down’ position of curiosity; collaborating rather than directing. Suggestions may be framed with ‘your story reminds me of a client who did x. I don’t know if this would work for you but may be you’d like to experiment with this and tell me about it?’ Or ‘The books say x helps a lot of people, I wonder if this would be helpful or unhelpful for you?’

**Comment [L1]:** Correct reference

People with ID who engage in face to face therapeutic work.

Adaptations to the approach for people with mild ID, who use spoken language, mostly focus on simplifying language and using visual aids in ways that will be familiar to most practitioners in the field. The area that requires most consideration is the hypothetical future or the miracle question.

SFBT already uses the client’s own words and language. It is generally helpful to use short sentences, commonly used words and visual material or signs to back up speech or to use items such as a sand timer to show the passage of time. Some people, often individuals with Autism, have expressive language that exceeds receptive language skills leading to an over estimation of their comprehension. A speech and language assessment can helpfully inform the therapist; so that the therapy is pitched to the client’s receptive and expressive language skills. Roeden et al (2009) gives examples of how SFBT questions can be asked simply e.g. ‘what is better since ...?’ ‘What are you hoping for?’ Bliss (2001) explains how the focus on the present rather than the past is helpful to those with poor memory recall. Also the focus on concrete

observable details of every day life can be helpful for individuals who find abstract concepts difficult to understand.

Raffensperger (2009) discusses factors associated with good outcome in therapy for people with ID. He suggests that using the client's resources e.g. tenacity is more important to therapy than technique. The SFBT focus on strengths, resilience, exceptions to the problem and compliments draw attention to competencies. This may be quite alien but helpful to people with ID who have had years of 'problem focused' narratives about their lives. An adolescent with Autism described in Lloyd & Dallos (2006) literally voted with his feet, joining the room and conversation as compliments and exceptions were discussed but wandered out at other times.

The hypothetical future is perhaps the most challenging part of SFBT when working with people with ID and autism. Particularly individuals who are very literal, have difficulty with abstract concepts, imagining the future and have single channel attention in which one small detail is focused on rather than the whole picture. Lloyd & Dallos (2006) described an adolescent with autism, mentioned above, who found the hypothetical future question difficult, shouting 'I need a magic wand now' and focused on one small detail, 'holding a girls hand'. This began to feel risky and narrowing rather than broadening the vision of how things could be different. Yet Bliss and Edmonds (2007) demonstrate in a book on SFBT and Asperger's Syndrome that the approach can be used with individuals on the autistic spectrum although alternatives to the miracle question tend to be used.

The majority of reports of SFBT with people with ID asked alternatives to the miracle question. Roeden et al (2009) suggest asking 'What will it be like when the problem is solved?' 'What are you wishing for?' 'What will you be doing on a really good day?' Clients may chose or draw pictures to show their preferred future. One client brought a picture of Princess Diana when thinking about her own preferred future. She explained that the princess had experienced a difficult childhood, had lost her partner and had little contact with her children. The client also wanted to survive her own similar losses with beauty, dignity and be loved.

Rating scales and goals can readily be adapted for people with ID and will be familiar to therapists working in the field. Stoddart et al ( 2001 ) simplified the 10 point scale

to a 3 point scale, but others have creatively used line drawings of facial expressions, building bricks, pictures of ladders, thermometers, stepping stones or circles divided into portions and collages of preferred futures or self-portraits (Roeden, 2009, Roeden & Bannik 2007; )

Comment [L2]: Roeden et al, 2009

The inter-session task is probably best not referred to as 'homework' which is likely to have negative connotations for people with ID. There may also be issues with remembering the assignment or practicalities in carrying it out.

Stoddart et al 2001 suggested that modified SFBT was most successful for those who were more able, self-referred and were supported in the therapeutic process by others. Clients with fewer presenting problems and whose problems were related to self-esteem, family and loss appeared to do better when rated by clinicians. This is in keeping with other psychotherapy research. The more resources and the fewer problems, the better the outcome is likely to be.

When people with ID access SFBT with the assistance of a trusted supporter or carer some adaptations are necessary to engage the carer constructively. Bliss (2005) reflects on how this can be complex when what the client wants contradicts what the referrer or carer thinks 'would be best'. As long as the client's goal and carer's goal are not mutually exclusive it is possible for both parties to have goals. If the goals are incompatible the client's goal remains paramount and the carer's task becomes finding ways of accepting and valuing this. Sometimes a parallel joint goal or an agreed quid pro quo can be negotiated.

#### SFBT with support staff or parents

Therapeutic work can be carried out with the carers e.g. Rhodes (2000) or parents (Lloyd & Dallos 2006, 2008). Little or no adaptation is required to the approach for this; although the miracle question remains controversial. Overall SFBT contains many elements that the literature suggests are helpful to parents caring for a people with ID. Knox et al (2000) report that parents find it helpful when professionals acknowledge that caring can be a positive, gratifying and personally enhancing

experience. They also indicate that for parents a vision of a promising future helps to create a sense of control over family life.

SFBT with people with ID who have little or no language.

For this group the adaptations to the approach are so great that it is better described as interventions informed by solution oriented thinking. Behavioural observations can focus on exceptions to a problem or after a functional analysis has been conducted observations can focus on naturally occurring adaptive behaviours that the client uses to meet his or her needs (Bliss, 2012). Behavioural records can be used to better understand exceptions to the problem by examining setting events, interactional styles, antecedents and consequences or posing the question ‘what helps this client be so good?’

Murphy and Davies (2005) used ‘self modelling’; a competency based intervention in which the client, a boy with ID, watched videotape of himself engaged in desired behaviours, using sign language, rather than acting out to communicate.

#### Cautions

SFBT is a relatively new therapeutic approach, that has only very recently been adapted for people with ID, the evidence base for SFBT is still emerging. Exploratory studies have been cautious and excluded high risk individuals. For example Stoddart et al (2001) excluded people with ID who required more than psychotherapy, had ongoing serious mental health concerns, risk of suicide or homicide, a long term intervention was indicated or multiple problems. Therefore the evidence base where it exists is not robust enough to generalise findings to complex situations with people with ID. Yet a protective factor is the therapist’s ethos of maintaining a genuine curiosity about what is helpful to the client and seeking the evidence about what works for that particular individual. Where the approach may be contra-indicated will become more evident as more outcome studies are published about people with and without LD.

The evidence for using SFBT in services for people with learning disabilities



The evidence for using SFBT is presented for a) face to face therapeutic work with people with ID with verbal skills; b) face to face work for people with ID who have little or no language; c) SFBT with carers as a consultation tool, and with d) carers as a training tool.

### *Case studies /descriptions/qualitative research on process*

Bliss (2005a, 2005b, 2010, 2012) and Roeden et al (2005) provide descriptions of adapted SFBT successfully used with people with mild LD who use speech. Smith (2005) presents a case study of 'Dave' a man with mild learning disabilities referred for anger management. He was seen, together with his support worker, by a Clinical Psychologist for 5 sessions of SFBT lasting between 60-90 minutes over an 11 month period. Much of the first two sessions were spent in 'problem free talk'. Some time was spent identifying characteristics of problem situation so that exceptions could be explored i.e. high risk times when the client had not become angry. The client looked at his preferred future and scaling questions were used. Between sessions 'Dave' spoke to significant others about what he found helpful and unhelpful in controlling his anger. He also reported how he had dealt with new provoking incidents and received positive feedback. The author noted that for this particular client the most helpful technique was finding exceptions to the problem behaviour and doing more of what helped to create those exceptions. He also noted that spending time discussing the present, future and strengths helped 'Dave' to remain engaged as the author sensed that a discussion about problems may have embarrassed the client to the point he would not return.

Comment [L3]: 2009

Case studies of direct SFBT work with those PEOPLE WITH ID with little or no language are emerging. Bliss (2012) describes using SFBT principles with 'Beth' a resident in a home for people with autism, she self-injured, engaged in flicking, rocking, screaming and playing with saliva. As 'Beth' did not speak staff voiced the preferred future for 'Beth' and gave examples of times when she responded positively. Exception seeking was combined with behavioural observations of 'exceptions' and intensive interaction techniques (Firth, 2006).

For those with little or no language solution focused consultation can be carried out with their carers or family members. Lloyd & Dallos (2006, 2008) described the use

of SFBT as a first session tool with mothers who consulted a Clinical Psychologist about their children with moderate to severe learning disabilities and a behavioural or emotional difficulty. A thematic analysis of seven initial sessions was conducted. Pre-treatment change, exception and coping questions led to pictures of remarkable, skilled, committed parents who were proud and stoical. The mothers discussed problems alongside strengths and solutions. The miracle question led to a change of pace. Six of the mothers described a miracle in which the child would no longer have the disability. It seemed that 'wishful thinking' allowed the mothers to reveal a covert hope and this was accepted as a part of their thinking and coping. Alternatives to the miracle question yielded fuller replies and details of a desired future. Initially these were vague but became more specific and concrete with prompting. The mothers integrated the scale and numbers into their conversation. The scale seemed to hold the hope of the miracle, more realistic possibilities and captured the present reality. The mothers began to put 'wishful thinking' aside and created a narrative in which the mothers made change happen. They began to problem solve, identified more exceptions and built on them and strategies that worked. Goals were set and were about managing the children's difficulties. Some of the mothers revisited exceptions at this point in the session, they seemed to need to do this before moving on to the inter session task. It was as if the mother's self efficacy needed to be underlined. Compliments were given to the mothers and inter-session tasks were generated collaboratively. Often the mothers complimented themselves and their child at the end of the session without prompt from the therapist. It seemed to the authors that SFBT created a collaborative working alliance in which the mothers perceived themselves as resourceful and the agent of change. Future research could usefully look at locus of control as an outcome measure.

SFBT may also be taught to staff with the aim of improving interactions between PEOPLE WITH ID and those with whom they spend time. Smith (2011) conducted a qualitative investigation into the effects of a two day SFBT workshop nine months previously on six social workers' practise. Specific techniques were not consistently adopted but most workers reported improved communication, collaboration and increased feelings of control and self-efficacy for their clients and themselves. Some difficulties in transferring the skills from the training event to day to day interactions

included organisational support and perceived conflicts between SFBT and the social work role in the UK.

The case studies and latter two qualitative studies cannot be used to make statements about the efficacy of SFBT or to produce replicable data. However sharing experiential learning may provide insight into the processes that can be at work in SFBT particularly when themes recur across studies. The reader is invited to judge whether the approach might be useful in their own practice from the detail provided. This seems to mirror the development and practice of the SFBT approach, in which there is exploration of what works and an invitation to others to try and find what works for them and their clients.

**Case studies with outcome data and single case experimental designs.** In the SFBT model self rating scales are used at the initial and subsequent sessions. Despite this in built data there are few published case studies with outcome data. Murphy and Davis (2005) presented an empirical case study of a nine year old boy with moderate learning disabilities who had a repertoire of twelve sign language signs but tended to communicate by pointing, grunting, shouting or hitting. The intervention aimed to increase expressive communication by more signing. In the intervention the boy was shown video clips of himself when he did use signs i.e. self modelling the exceptions. The context in which these exceptions occurred was explored. The mean percentage of 10 second intervals during 10 minute observation periods in which he signed increased from 23% in the baseline to 71 % during the intervention and at one month follow up in 64% of the intervals.

Rhodes (2000) described SFBT as a consultation tool in eight sessions over six months with care staff who consulted a Clinical Psychologist about a 36 year old female client with severe learning disabilities. The miracle question was not asked instead staff were asked ‘What arrangements would be ideal?’ for the client. At the outset regurgitation occurred with a frequency of 1.34 episodes per day with only 3 days with no regurgitation. By the eighth session there had been no regurgitation for four weeks. The author found SFBT a useful approach with care staff in particular the focus on strengths, non blaming stance and the way carers generated solutions which built on their competencies. The nature of these two studies means that factors other

than SFBT could be at work and account for the successes. This is overcome to an extent with multiple baseline designs.

#### **Case series reporting outcome data.**

Roeden, et al (2011) undertook a series of case studies with outcome data for ten PEOPLE WITH ID assessed as having a mild learning disability. All the PEOPLE WITH ID lived semi-independently and received individual support from paid care staff for a few hours a week. The reasons for engaging in SFBT included alcohol abuse, anger, bereavement, depression, sleeplessness, low self esteem and avoidance/anxiety. Each participant was provided with five sessions of SFBT over a twelve week period. A carer was always present in sessions. Measures were taken of: a) quality of life, b) maladaptive behaviour, c) goal attainment according to the PEOPLE WITH ID, d) goal attainment according to the carers. Measures were taken before SFBT began, after SFBT and at a 6 week follow up. Statistically significant improvements were found on the composite measure of quality of life and psychological functioning ( $p < 0.01$ ) and this was maintained at follow up. No statistically significant changes were seen on the group's social functioning sub-scale scores. On the maladaptive behaviour scale, in which a carer assessed the client, eight of the ten clients were assessed as having clinically relevant decreases in psychological problems directly after SFBT and this was maintained at follow up. Clients' own ratings of goal attainment and that of their carers indicated that seven of the ten clients attained their goal, and this was sustained at follow up. For the remainder progress towards the goal was made.

Comment [L4]: 2011a

In a similarly constructed case series study Roeden, et al. (2012) looked at solution focused coaching of care staff who worked with PEOPLE WITH ID in the severe and moderate range. Thirteen teams of care staff, comprising of forty two female staff members, took part. They provided care in residential or vocational settings, 95% had undergone three years professional training e.g. in nursing, occupational therapy. The staff received solution focused coaching with up to three sessions over a nine week period. The miracle question was asked on occasion but at other times alternative means of eliciting a vision of a positive future were used e.g. 'Suppose we make a video showing the most desirable support situation. What do we see and hear on this video?' Measures were taken directly before and after SFBT and at six weeks

afterwards. Measures were a) progression towards the goal using the Scale Question Progression (Bannink 2010), b) proactive thinking using the staff-client interactive behaviour inventory (Willems et al 2010) and c) the Student Teacher Relationship Scales' (Koomen et al 2012).

Progression towards the goal was shown to be substantial for seven teams, smaller for four teams and hardly any change for two teams. The mean increases on the progression towards the goal scale, proactively thinking and quality of relationship were statistically significant ( $p < 0.05$ ). **the** authors concluded that SFBT can be a useful tool to build relationships between carers and people with ID.

Comment [L5]: T

These two studies are more rigorous than the preceding case studies, with clear descriptions of the intervention and the clients. The outcomes were measured with recognised tools and simple statistics were used to compare group means to make judgments about the likelihood that chance caused the results. But the studies do not indicate how SFBT compares to other interventions. For this it is necessary to use controlled trials.

### **Controlled trials**

At the time of writing there do not yet appear to be any randomised outcome controlled trials of SFBT for people with ID in therapeutic settings.

### **Meta analyses**

There is not a meta analysis of single case studies or outcomes studies for SFBT and people with ID, there are insufficient studies to draw on.

### **User views**

A number of the studies described above consider user views. Roeden (2011a) sought participants' views using the Session Rating Scale (Miller, Hubble and Duncan 1996) adapted for people with ID. Feedback from the clients was generally positive.

Stoddart (1999) asked clients with mild learning disabilities and their carers to take part in a satisfaction survey by telephone 6 months after therapy was completed. This in itself raises questions about the reliability and validity of the results if the people

with ID had difficulties with memory or abstract concepts. The mean scores for SFBT clients was compared to two groups a) mental health patients who provided the norms for this measure and b) people with ID receiving long term psychotherapy from the same service. The three groups expressed similar levels of satisfaction , however the SFBT group scores were lower than the mental health service users on their perception that the service met their needs and their perception that the length or number of sessions was insufficient.

Lloyd & Dallos (2008) sought the views of seven mothers who participated in SFBT initial sessions regarding their child with learning disabilities. Two weeks after their session mothers were interviewed using the helpful aspects of therapy questionnaire (Llewellyn 1988) and structured recall (Elliot and Shapiro 1988) i.e. parts of the session identified by the mothers was located on an audio tape of the session, listened to in order to prompt recall and discussed by the mothers. The interview was recorded, transcribed and a thematic analysis conducted using interpretative phenomenological analysis (Smith, 2003).

Three themes emerged from the mothers' accounts 1) SFBT amplified or brought to mind a stance of 'making the best of it'. This involved choosing how to appraise the situation either as victims or to 'make the best of it'. 'Making the best of it' also involved the looking to the future, hope, self efficacy and self worth. 2) The SFBT sessions led them to examine 'wishful thinking'. This was complex, the miracle question was reported to be the least helpful aspect of the session. Yet some revealed that they held covert hopes for a miracle 'cure' but went on to explain that change happened because of them and their efforts. A narrative which reinforced their sense of self efficacy emerged i.e. change came about by their efforts. The miracle question was distinguished from the vision of the future and scaling which were perceived by all mothers to be the most helpful aspect of the intervention. 3) The third theme in the mothers' accounts was the therapeutic relationship, they valued time to think and hopefulness. There was some disappointment that the therapist was not a directive expert, echoing the covert hope for a 'miracle cure'. Yet alongside this they valued the collaborative nature of the therapeutic alliance in which their expertise and ability to create change were amplified.

Some authors have noted that SFBT components are similar to those that are associated with good outcomes in therapy or are helpful for people with ID. Roeden et al (20011 b) sought the views of seventeen people with ID on factors that contributed to a successful working relationship with their support staff. The Nominal Group Technique was used to generate individual ideas, list, clarify and rank the ideas. The highest ranking ideas included 1) listens well, takes me seriously, or asks questions 2) makes time for me 3) is reliable, 4) lets me do things myself or solve them myself. Once this was done the question was asked ‘To what extent do the opinions..... correspond with the core assumptions of SFBT?’ The authors concluded that the people with ID views did correspond to the core assumptions of SFBT, although those ideas appear to be relevant to a number of counselling and psychotherapeutic interventions.

### **Conclusions**

SFBT is emerging as a way of working therapeutically with people with ID. A key piece of feedback from clinicians, clients and parents is to a preference for alternatives to the miracle question to elicit a vision of a preferred future. The approach, because it is derived from helpful aspects of therapy, has high face validity and corresponds with factors identified as helpful in therapy for people with ID. Whether SFBT increases self-efficacy or locus of control is an interesting question and is worth considering as an outcome measure. The clinical studies, evaluations and outcome studies, whilst limited in number, do seem to suggest that SFBT is as effective as other approaches but may be briefer than some psychological therapies, therefore providing outcomes more efficiently. However, clinical studies with outcome data and controlled trials are needed before SFBT can be used with confidence with people with ID.

### **Service examples**

In the UK Vicky Bliss practices SFBT with adults with learning disabilities and people with the label of Asperger’s Syndrome. Her web site is: [www.missinglinksupportservices.co.uk](http://www.missinglinksupportservices.co.uk)

Alasdair MacDonald maintains a record of outcome research on SFBT on his web site [www.solutionsdoc.co.uk](http://www.solutionsdoc.co.uk)

The Brief Therapy Practice in London is a hub for much of the SFBT training and development in the UK although other regional centres are developing too.

With regards to references:

Bliss 2012 – she has more than one and I don't know which one you used.

Bliss 2005 a/b I've referenced a 2005 paper but that is the only one I have seen.?!

Roeden 2005 – doesn't seem to exist/I cannot find it.

Comment [L6]: 2009

We already talked about taking out the 1992 de Shazer and Berg reference as it is wrong (his fault not your own).

There are one or two you did not put dates on so obviously haven't been able to reference these!

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