Solution focused Support for People with Intellectual Disabilities

Experiences of Learning Caregivers

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Abstract

Introduction: Solution focused support (SFS) is a positivist approach that involves emphasizing clients' self-efficacy, competences and resources to accomplish personal solutions, as opposed to focusing on problems and its antecedents. The solution focused model is regarded as widely applicable and one field of application is the sustained care in assisted living for people with intellectual deficiencies (ID). While results of research regarding the usefulness of the model with this population are promising, there have not been many studies conducted on the process of learning to employ solution focused practice in this context. There may be aspects of the approach that are more difficult to apply successfully and circumstances in which learning caregivers may find it problematic to use SFS. Identifying these factors is relevant in order to ensure optimal training in SFS and to adjust the practice of care to fit the recipients. Addressing these issues, this study had two major objectives: firstly, to find out which aspects of SFS are more often deployed in client-interactions in which SFS is applied successfully. And secondly, to identify factors that are perceived as impeding the application of SFS.

Methods: 164 caregiver experiences were analyzed for the frequencies of techniques used in interactions with clients, which were subsequently related to the perceived success of respective situations. This was done by labeling used techniques and aspects of SFS, based on the theory of SFS and by employing a bottom-up approach, and relating these to caregivers' perception of success of interactions with clients by creating multiple response sets in SPSS and computing cross tabulations. Furthermore, caregiver experiences were scrutinized for factors that caregivers had perceived to obstruct the application of solution focused methods.

Results: Caregivers were, for the most part, able to use the solution focused model successfully in caring for people with ID. However, there were some aspects of SFS that were more often employed than others, and some were very rarely utilized. Furthermore, in some instances caregivers found the solution focused approach not applicable, for instance when clients did not respond to it right away, when there was a conflict present or when caregivers were short on time. Caregivers then tended to opt for an alternative, non-solution focused approach.

Conclusion: The results of this study supplement the notion that the solution focused approach is fitting for caring for people with ID. Also it showed that caregivers, who are relatively new to SFS, are quite able to use its methods effectively. However, the training of caregivers on some less frequently employed aspects of the model may have to be revised as well as on how to apply the approach to situations, which caregivers perceive as difficult.

Samenvatting

Introductie: Oplossingsgericht werken (OGW) is een positivistische benadering die gericht is op het benadrukken van de zelfredzaamheid, de competenties en de hulpbronnen van cliënten om persoonlijke oplossingen te bereiken, in plaats van het focussen op problemen en diens antecedenten. OGW wordt beschouwd als een veelzijdig toepasbaar model en een gebied van toepassing is de dagbesteding en zorgverlening voor mensen met een verstandelijke beperking. Ondanks de positieve resultaten van onderzoeken naar de doeltreffendheid van het model met deze populatie, worden er tot op heden weinig studies uitgevoerd naar de ervaringen van zorgverleners die opgeleid worden in het gebruiken van deze benadering. Mogelijkerwijs zijn er bepaalde aspecten van OGW die moeilijker op een succesvolle manier toe te passen zijn en situaties voor die zorgverleners de benadering minder geschikt vinden. Voor de kwaliteit van trainingen in OGW en voor een optimale zorgverlening is het van belang om deze vraagstellingen in kaart te brengen. In totaal zijn er twee doelstellingen geformuleerd in deze studie: Ten eerste, welke aspecten van OGW worden vaker toegepast in cliëntcontacten waarbij de zorgverleners oplossingsgericht te werk gaan? Ten tweede, wat zijn factoren die de gepercipieerde toepasbaarheid van OGW beperken?

Methoden: 164 rapportages van zorgverleners over diens ervaringen met OGW werden geanalyseerd naar de frequenties van de technieken die werden gebruikt. Dit werd gedaan via labeling, gebaseerd op de theorie van OGW en een bottom-up benadering. Vervolgens werden deze frequenties gerelateerd aan het waargenomen succes van de respectieve situaties, door middel van multiple response sets die werden gecreëerd met behulp van SPSS en vervolgens in cross tabulations werden tegenovergesteld. Bovendien, werden de rapportages van zorgverlener kwalitatief geanalyseerd naar waargenomen factoren die het toepassen van OGW hebben voorkomen.

Resultaten: Voor het grootst deel zijn zorgverleners in staat geweest om het oplossingsgerichte model toe te passen bij mensen met een verstandelijke beperking. Daarnaast werden sommige aspecten van OGW vaker gebruikt dan andere, en enkele aspecten werden bijna nooit toegepast. Bovendien vonden sommige zorgverleners dat OGW niet geschikt is in sommige situaties, bijvoorbeeld als cliënten niet op de toepassing hebben gereageerd, als er een conflict aanwezig was of als de tijd van zorgverleners krap was bemeten. In dit geval gaven zorgverleners vaak de voorkeur aan een directieve, niet-oplossingsgerichte benadering.

Conclusie: Deze studie biedt onderbouwing voor de opvatting dat OGW een geschikte benadering is voor de begeleiding van mensen met een verstandelijke beperking. Daarboven laten de resultaten zien dat zorgverleners wel in staat zijn om de oplossingsgerichte benadering

effectief toe te passen. Desondanks zijn er aspecten van OGW die beter getraind kunnen worden. Ook zou er aandacht moeten zijn voor de toepasbaarheid van de benadering in moeilijke situaties.

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1. Introduction

There are a vast number of different approaches to mental health care and counseling based on various theoretical frameworks, and almost as many preferences and convictions about their effectiveness and practicability in different settings of application (Wampold, 2001). One of these approaches is solution focused therapy (SFT), which was originally conceptualized as a discrete form of family therapy by Steve de Shazer and Insoo Kim Berg and the efforts of their team at the Brief Family Therapy Centre in Milwaukee, Wisconsin (Cunanan, 2003). They found, that helping the client to find ways to improve his/her situation and focusing on positive and constructive aspects of the client's life, is an efficient alternative to traditional approaches which emphasize the problem and its causes (O'Connell, 2005). The approach includes i.e. stimulating the client to imagine a positive vision of the future without the experienced problem, invoking a sense of empowerment in the client, mobilizing personal resources of the client by referring to instances when the client was able to successfully deal with his/her struggles and encouraging the client to formulate small goals towards a solution. In solution focused practice, the client is considered an expert on his/her own life and issues, equipped with means to help him/herself, while the practitioner assumes the role of a co-expert that supports the client in accessing his/her potential (Knight, 2004). Solution focused therapy, therefore, comprises a paradigm shift from conventional problem focused approaches, in which the focus lies on the problem of the client and its antecedents and a reliance on the expertise of the professional in guiding the interaction to a solution.

Over the course of a little more than two decades, solution focused therapy has become one of the most widely used approaches to therapy and counseling in the world (Trepper, Dolan, McCollum, & Nelson, 2006). One of the major benefits of SFT is its focus on the client and his/her resilience and innate ability to deal with the specific problem at hand. This client-centeredness, and the underlying assumption that individual clients hold the key to their specific dilemma, allows the approach to be applied to a broad variety of problems and populations (Trepper et al., 2006). For that reason, the SFT was adapted and implemented by practitioners of many fields (Grant, 2012) and was deemed efficient in a diversity of settings of therapy and non-mental-health-related counseling (de Shazer et al., 2007). One field of application is to be found in the work with people with mental disabilities. The utilization of SFT for this population seems promising because of the emphasis on empowerment and the client-centered nature of this approach (Roeden, Maaskant, Bannink, & Curfs, 2011). Also, Roeden, Maaskant, and Curfs (2010) indicated in a pilot study, that clients with intellectual disabilities (ID) show a preference for solution focused support (SFS) of their caregivers, which has im-

plications for a trusting client-practitioner relationship. However, the effective application of this approach requires sufficient training of caregivers (Roeden, 2012). For that matter, assessment of experiences of practitioners in training is essential in order to find out how the learning process transpires in the field, and to safeguard a wholesome integration. However, the few studies that have addressed this subject yielded varying results, indicating that, while caregivers adapt their practice towards favoring a solution-oriented focus which is generally deemed beneficial to the clients, application is often inconsistent and its success conditioned by a multitude of factors (Smith, 2011).

Therefore, the aim in this study was to examine experiences with SFS provided by practitioners, novice to this approach, working with mentally disabled people in assistant living accommodations, in order to get a better understanding of how beginning caregivers are able to put the learned skills to use and to ascertain areas of the training process which could be improved. Since the approach is so widely employed, findings from research on efficacy of the solution focused model applied to various settings will be reported in the following. Subsequently, the purpose of this study and its research questions are disclosed.

1.1 Research on the solution focused approach

The widespread popularity of any approach, does not account for its efficacy and policies on the implementation of interventions are made based on empirical support from outcome studies. For that matter, there is a growing interest in the effectiveness of solution focused approaches and an increasing amount of research on their usefulness has been conducted over the recent decennia. For example, in 2000 Gingerich and Eisengart analyzed the outcomes of 15 studies on the efficacy of SFT and found implications for beneficial effects of this approach. In an ongoing effort to evaluate the efficacy of solution focused therapies, Gingerich and Peterson (2012) did show that this approach yields significant benefits, even when scrutinized in experimental or pseudo-experimental settings.

Results of research endeavors around the globe on SFT show that solution-oriented interventions are effective in treating a variety of disorders and problems. For instance, in reducing depressive symptoms, anxiety, substance abuse (Lovelock, Matthews, & Murphy, 2011), recidivism rates and severities of committed offences in inmates (Lindforss & Magnusson, 1997) and in reducing maladaptive, behavioral and cognitive difficulties in adolescents in foster care (Cepukiene & Pakrosnis, 2011). These findings have not only economic implications due to the usual briefness of the interventions, but also suggest a high degree of

applicability and usability in and outside of therapeutic settings, since positive research results stem from studies conducted in a broad variety of contexts and on different populations.

1.1.1 Solution focused support for people with intellectual disabilities

SFS seems to be a good fit when it comes to working with people with intellectual disabilities, since its conception of the client as the expert and its emphasis on self-efficacy and empowerment in the client follow the prevalent thought of efficient practice with this population (Roeden et al., 2011). Furthermore, clear communication is not always possible with clients with ID. Therefore, focusing on the antecedents of problems in the past is seldom fruitful. Solution focused approaches and their view on possibilities in the present and future are for that reason more suitable than problem focused approaches in working with this population (Westra & Bannink, 2006). Additionally, the cooperative and coequal character of relationships in SFS interventions seem to have positive effects on the bond between caregivers and clients, which is especially important in sustained care for individuals with ID (Roeden, Maaskant, & Curfs, 2010). Up to this date, research on the benefits of the solution focused approach for clients with intellectual disabilities is scarce, but preliminary results are generally promising (Roeden, 2012; Maastricht University, 2012).

1.2 Purpose of this study & research questions

Every adaptation of a form of therapy involves deviating from its original conceptualization. Therefore, application to settings other than the ones initially intended bear the potential that individual techniques do not yield the expected results or cannot be exercised without sensitive adjustment to the specific situation. While the conduct of research on the receiving end of solution focused support is increasing in recent years, the providing side has not gotten much attention. But as Roeden (2012) noted, proper training is the base for an effective treatment. De Shazer himself cautioned about the seductive simplicity of solution focused practice (Trepper et al., 2006). Some basic solution focused techniques may be learned relatively quickly by practitioners in training, but it can take a long time and experience until a professional level of expertise is reached and a sense of what works for the individual client and situation is attained (Hagen & Mitchell, 2001). As Nylund and Corsiglia (in Cunanan & McCollum, 2008) mentioned, sometimes caregivers who are new to SFS may attempt to apply this approach in an inflexible manner which results in ‘solution forced’ practice and may leave the clients neglected. Surely, a question of experience, since an adept caregiver may find more productive ways of working in a solution focused fashion while acknowledging the

client. However, identifying obstacles and facilitating factors experienced by caregivers novice to SFS, is imperative in order to ensure training is efficient and no resistance to the model is developed.

Till now, no research has been conducted on applying solution focused techniques on people with ID, concentrating solely on the experiences of newly trained caregivers. Therefore, this bachelor thesis examines experiences of practitioners, who are still learning to work solution focused with people with intellectual disabilities. As the solution focused approach comprises many different dimensions and techniques, one goal is to find out if there are elements of SFS that are more easily and frequently utilized than others by learning caregivers and if so, whether or not some elements are relatable to the perceived success of client-caregiver interactions. Furthermore, this study sets out to identify factors that are perceived to hamper the success in attempting to apply the solution focused approach on the population. These emphases of the study are concerned with the aforementioned experience-dependence of the approach and could provide indications for the refinement of trainings in solution focused support. Based on these main intentions of this study, the following research questions are formulated:

1. Which aspects of SFS were most frequently described by caregivers in practical applications that were perceived as successful?
2. What are situational or client-related aspects provided by caregivers that prevented them to successfully apply SFS?

1.3 Research context

As mentioned, one area of application of solution focused methods, outside of the strictly therapeutic setting, lies in mental health organizations which support mentally disabled people. Aveleijn is one of those organizations, located in the central region of Twente in the Netherlands. It supports about 2300 clients, occupies about 1500 employees and provides sustained services in assisted living, daycare, medical care and therapy for children, adults and families with mental deficiencies. Aveleijn emphasizes solution focused methods, and heath care professionals working directly with clients are trained in the solution focused approach. For this reason, Aveleijn was a suitable setting to conduct this study with the aforementioned research questions on the experiences of caregivers that are novice to solution focused practice in working with people with ID.

2. Methods

This research relies on a completed longitudinal study in which new employees of Aveleijn were followed over a period of one year, by means of interviews and an online log-book about their experiences of working with the solution focused approach. For the objective of this study, these written accounts of- and transcripts from interviews with caregivers were used. In the following, the procedure of selecting the sample, the sample characteristics and methods of data collection will be disclosed.

2.1 Recruitment & the sample

The sample was attained over the course of 12 months and, due to the explorative character of this study, it was aimed for a sample size of approximately 15 participants. The inclusion criteria were: employment at Aveleijn for less than a year and intention for a long-term engagement, and direct contact with clients as part of the job description, while more and wanted contact was deemed best. Also, only participants who recently completed their training in solution focused support and who consented to participation and collection of personal work-related data were included.

The ideal sample, which was aimed for, was composed of 5 caregivers, 5 assistant caregivers and 5 staff members otherwise professionally involved with clients in their daily activities, in order to get a broad view of application possibilities and experiences.

For the selection of the participants, location managers were asked to look for personnel that might fit the inclusion criteria and to ask them if they would be willing to take part in the study. This choice was made, because contacting location managers in order to recruit participants was the most straightforward way to get access to the population.

Initially, there were 20 employees that indicated interest in participation. In the course of a first meeting with the researchers, all participants were informed by means of a Power-Point presentation about the goals of the study and what taking part would entail, in terms of invested time and requested disclosure of information about their work. Moreover, it was assured that the data the participants may provide would be handled with responsibility and confidentiality. The participants were then asked to sign the informed consent if they agreed to all conditions of participation.

Due to personal reasons and work-related constrains, four participants left the study, resulting in an overall sample size of 16. Furthermore, because this study is concerned with experiences of those directly working with clients with ID in their everyday routines, only caregivers and assistant caregivers were needed, reducing the sample size further to 11 partic-

ipants. Of these, one caregiver was excluded in the further analysis, since the participant was more experienced in working with the solution focused approach and therefore not at the same stage of the learning process as the other participants.

The final sample consisted of eight women and two men between the age of 24 and 53 (M = 37.56, SD = 9.62), which is a relative accurate representation of the variation in the overall population of caregivers occupied by the organization. All participants were recently employed by Aveleijn (less than a year ago) and their working experience in the context of mental health care ranged from 25 years of experience in the field, to no previous experience at all.

2.2 Data collection

At the beginning of data-collection, participants were contacted by email and instructed to fill out an online logbook (see Appendix A) every two weeks on the experience of working with the solution focused approach. When making an entry in the logbook, caregivers were asked to indicate whether or not they were able to consciously apply solution focused support in the last two weeks. Furthermore, participants were asked to remember one specific moment they had encountered during that period, based on the following given scenarios: 'Solution focused Support was applied successfully', 'Solution focused Support was applied but not successfully', 'Solution focused Support was not applied but could have been applied successfully', and 'Solution focused Support was not applied and could not have been applied successfully'. In addition, participants were prompted to fill out a work engagement scale which contained statements on attitudes and perceptions regarding their occupation (see Appendix A). 12 months after starting the data collection, participants were invited to an interview. On this occasion, caregivers were asked to answer questions pertaining instances they had described in the logbook and resolve ambiguities in their accounts. Furthermore, the interviewers enquired the caregivers' opinion about working with the solution focused approach after one year of practice and how they experienced their participation in the study.

2.3 Data analysis:

In preparation of the data analysis and in order to get more acquainted with solution focused practice at Aveleijn, the author of this work attended three of five trainings that newly employed caregivers have to attend to as well. Materials provided in the course of the trainings as well as in used literature were essential for the data analysis, since both are based on the works of Louis Cauffman.

Sources of information used in this study, were the contents of the logbooks that caregivers had created in the 12 months of data collection, as well as the logbook-related fragments of the transcripts from interviews. In preparation of the main analysis, eleven of the 164 total logbook fragments and their respective interview transcripts were discarded, because these entries were mainly about caregivers stating that they could not remember an example or did not have time to write up an interaction with a client, leaving 153 fragments in total that were used in the analysis. In the following, a documentation of the analysis for each research question will be disclosed.

2.3.1 Aspects of SFS most frequently used in situations perceived as successful

To answer the first research question, the aspects of SFS that caregivers had employed, as indicated in respective logbook entries and interviews, were labeled by the researcher of this study and related to one of the four scenarios for which caregivers had provided the individual experiences. Fragments and transcripts were labeled based on Cauffman's theory of SFS, and labels supplemented from a bottom-up approach during the course of the analysis. Moreover, a pilot-study was conducted prior to the main analysis on 20 logbook fragments, through which an inter-rater agreement on the used labels was established and consequently the definitions of labels and the criteria to apply these were substantiated. It should be noted that for 41 of the 153 logbook fragments used in total, the classifications of fragments in one of the four scenarios was recoded, because either caregivers explained in the interviews that they had assigned a fragment to the wrong category (e.g. they had marked a situation in which they had applied SFS and which was overall successful, as 'Solution focused Support was not applied and could not have been applied successfully') or the described situation was obviously incongruent with the indicated scenario. The theoretical foundation of utilized labels is explained in the next section as well as criteria for application. Thereafter, labels used for conversational techniques that caregivers utilized are explained, followed by a description of additional labels that were devised from a bottom-up approach.

Labels based on Cauffman's SolutionCube

As mentioned, the biggest part of the labeling process was based on the works of Louis Cauffman, because his conceptualization of SFS forms the foundation of the care practiced at Aveleijn. Grounded on the central aspects of solution focused therapy by de Shazer and Berg, Cauffman devised the so-called 'SolutionCube' (an unfolded depiction can be found in Appendix B), a cubical geometric shape on which planes the most essential and intrinsically

related aspects of the solution focused approach are projected. In order to ascertain the application of the solution focused model from reported caregiver experiences, this study utilized aspects which are presented on three of the six sides of the cube: the *Flowchart*, *Mandates* and the *7 Step Dance*[1], which Cauffman also refers to as *the Solution Tango* (2006). These aspects of SFS were chosen because their application can be directly observed and therefore more readily assessed from caregiver accounts. Descriptions for the used labels are based on Cauffman's influential books *Simpel* (2010) and *The Solution Tango* (2006) and will be provided in the following for each of the utilized sides of the SolutionCube. Also, examples will be provided to illustrate to which kind of situations the labels were applied.

The Flowchart

The first side of the SolutionCube that was used is called the *Flowchart* and was designed as an aid for ascertaining the progress of the client-caregiver relationship and a help for decision making on how to position oneself as a professional in respect to the nature of the relationship at the given time. The relationship is determined by the client's ability to use own resources to generate solutions to his/her own problems and by the extent to which the client is aware of the issue at hand. The caregiver then reacts appropriately to the client's needs and stimulates, motivates or advises the client in advancing towards solution focused functioning. Each caregiver-client relationship is described in Table 1, as well as examples of application.

Table 1

The Flowchart and Respective Caregiver-Client Relations

Relation	Description	Example of application
Non-Committal Relation	No request for help by the client. Either the client does not see the problem and is issued to engage in the relationship, or the client does not want any extraneous help in solving it.	A client is frequently getting in fights with other clients. The caregiver approaches the client and addresses the problem.

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

[1] All translations of terms on the SolutionCube from Dutch to English were received from www.mindmelt.de

Table 1 (*Continued*)

Relation	Description	Example of application
Searching Relation	Client voices a request for help and acknowledges a problem, but has no idea how to resolve it. The caregiver helps the client to find possible solutions.	A client wants to refurbish his bedroom, but has no idea how to go about it. Therefore, he asks a caregiver for assistance.
Consulting Relation	Client acknowledges the problem and has some notion of what to do about it, but is not using his/her own resources to full effect. The caregiver emphasizes the client's abilities in creating own solutions.	A client asks a caregiver to make an appointment with a consultant in order to get advice. The caregiver explains that he is confident that the client can do that himself and proposes that he could accompany the client to the appointment.
Co-Expert Relation	Client is devising and applying solutions by him/herself and is aware of own resources. Caregiver lends support and motivates the client.	A client's scooter is broken and the caregiver asks the client what he intends to do about it. The client responds that he has to bring his scooter to a mechanic. The caregiver compliments the client for coming up with a solution.

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

The Mandates

The second side of the SolutionCube deemed relevant in this study, involves the *Mandates*. These are different forms of authority the caregiver has in every client-caregiver interaction. Cauffman defines three mandates which the caregiver always assumes at the same time, and which enable him/her to function in accordance with the profession: The *Manager*, the *Leader* and the *Coach*. The emphasis on one mandate, from which the caregiver performs,

is determined by the conditions of the situation and the authorizing client that is entering into the client-caregiver relationship. Each mandate is described and exemplified in Table 2 below.

Table 2

The Three Mandates

Mandate	Description	Example of application
Coach	The main task of the Coach is helping the client in coming to a solution by his/her own volition. When emphasizing the coach, the caregiver is engaged in stimulating, motivating and reinforcing the client.	A caregiver exerts a minimum amount of control in an interaction with a client. He listens to the client and compliments and encourages him when the he is acting conducive to finding a solution.
Leader	The Leader takes a more directive control in the relationship with the client. His task is to determine in which direction the interaction should be going, what the client should do differently or what to do next.	A client has no appointment for consultation and does not want to wait his turn. Therefore, the caregiver tells the client that he has to abide the rules as everyone else and should make an appointment.
Manager	The Manager has the obligation to create the basic conditions under which the client-caregiver relationship can be fruitful and which foster the functioning of the client.	A client has trouble keeping track of his expenses. The caregiver attaches a note to the client's receipt box, to remind him of the amount he is able to spend.

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

The 7 Step Dance

The *7 Step Dance* or *the Solution Tango* by Cauffman refers to a dynamic and flexible process in the interaction with clients and involves a number of techniques by which a beneficial relationship can be established and the client is helped towards generating solutions. The

7 Step Dance is not an algorithmic checklist the caregiver should follow rigidly, but rather a set of seven interchangeable methods that ought to be applied as demanded by the individuality of the client and the respective situation. This side of the SolutionCube incorporates techniques that are hallmarks of the solution focused model and are largely identical with techniques of de Shazer's solution focused brief therapy. Each technique of the *7 step dance* that was used to label caregiver behaviors, is described in Table 3.

Table 3

Techniques of the 7 Step Dance

Technique	Description	Example of application
Socializing	Encompasses caregiver behavior aimed at improving or investing in the client-caregiver relationship.	During an interaction a caregiver is making friendly conversation with the client which is not related to the problem of the client, but with the client him/herself.
Contextualizing	Caregiver is asking questions in order to find out as much as possible over the context of the client and his/her problem.	A client with family problems in a conversation with a caregiver. The caregiver asks: "Could you describe what happens when you come home?"
Goal-Setting	The caregiver encourages and stimulates the formulation of goals the client can pursue and accomplish.	A client is unsatisfied with work. The caregiver asks: "What could be done for that to change?"
Giving Compliments	The caregiver awards compliments to the client for participating in the relationship and in the pursuit for change, and for behavior conducive to a solution.	A client solved a long-term problem. The caregiver shares the accomplishment of the client with a colleague, in the presence of the client.

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Table 3 (*Continued*)

Technique	Description	Example of application
Exceptions	An alternative way to uncover resources. The caregiver refers to previous instances in which the client was able to solve his/her problem or the problem was like to occur but did not.	A client's birthday is coming up and he wants to throw a party, but does not know what needs to be done. The caregiver asks: "How did you do it last year?"
Differentiate	The caregiver helps the client differentiating between how things are and how they were and thereby showing the client that change is taking place.	A caregiver asks: "Do you remember how things were when we first talked about this issue? Do you see a difference to how they are now?"
Future Orientation	The caregiver stimulates the client to see solutions to problems in the presence and the past in the future.	"Keep practicing and you'll be able to do it all on your own in no time."
Uncovering Resources	The caregiver explicitly or implicitly underlines the strengths and capabilities of the client.	The caregiver challenges the client to try doing the laundry by himself and compliments him afterwards.

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Labels for conversational techniques:

Not part of Cauffman's solution focused model but also taught in the course of the trainings of caregivers who are newly employed at Aveleijn, are general conversational techniques, such as asking closed-ended- and open-ended questions, summarizing, probing questions and active listening. These techniques and respective descriptions and examples of application are shown in Table 4.

Table 4

Conversational Techniques

Technique	Description	Example of application
Active Listening	Actively listening to what the client has to say.	Letting the client talk and stimulating sharing by means of non-verbal and verbal encouragement.
Probing Questions	Continuously asking questions that arise from the client's account.	Keeping the client going in sharing, by probing, e.g. "Why was that?" or "What happened next?
Summarizing	Summing up the narrative of the client to show that one is listening and to clear up misunderstandings.	"You felt misunderstood because you were ignored and that's the reason you became hostile."
Open-Ended Questions	Asking an open-ended question to which a 'yes'/'no'-answer does not suffice.	"Tell me about your work."
Closed-Ended Questions	Asking questions to which the response is limited to 'yes'- or 'no'-answers.	"Did you have a good time with your parents this weekend?"

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Supplemental labels

30 supplemental labels, referring exclusively to behavioral techniques, were devised by taking a bottom-up approach and were categorized in three label clusters. Firstly, thirteen techniques involving solution focused thinking, meaning that they encompass caregiver behavior that is in line with fundamental principles of the solution focused model, such as stimulating the client and emphasizing his/her self-efficacy in the process of care (for a comprehensive descriptions of all techniques of this cluster see Table 12, Appendix C). Secondly, eleven directive techniques representing caregiver behavior that involves assuming directive role in the relationship with the client and influencing the client's behavior (directive tech-

niques are fully described in Table 13, Appendix C). Finally, six miscellaneous or neutral techniques, that neither involve solution focused thinking, nor directive behavior specifically (see Table 14 in Appendix C for an exhaustive description of techniques of this label cluster).

SPSS analysis

In order to be able to answer the research question of how techniques and aspects of solution focused support, such as mandates and relationships, relate to the four different scenarios of application and success, the gathered data, that was processed and condensed by applying labels, was contrasted quantitatively. To this end, multiple response sets were created by utilizing SPSS. Every possible technique, mandate and relationship for every described fragment was handled as a dichotomous variable with a true and a false alternative. This was done because the number of cases per fragment, defined by the acts performed by caregivers and characteristics of the situation described in one fragment, was only limited by the maximum amount of labels regarded in this study. Thus, while in one described situation only few techniques were used by a caregiver, in another situation a multitude of different techniques would be applied by emphasizing a different mandate and engaging in another relationship. When the goal is to compare a large number of diverse client-caregiver interactions, however, a disproportionate amount of partially, or entirely dissimilar parameters renders a comparison with numerical means very problematic. The use of multiple response sets circumvents this problem, due to the fact that every parameter for every analyzed moment has a value, even if it is untrue for the respective situation.

Once all data was entered into the dataset, descriptive analyses were conducted by calculating the frequencies of the four scenarios, to gain an understanding of how fragments were distributed over the dimensions of perceived success and application of SFS. This was also done in order to find out if there was a bias in participants to favor one scenario over the other when reporting their working experiences.

To ultimately ascertain how techniques, relationships and mandates were related to the four scenarios, cross tabulations were created by contrasting the variable scenario with the labels of mandates, relationships and techniques, individually. Subsequently, it was checked which mandates, relationships and techniques were most common for each scenario and whether or not there is a difference in occurrences over the four scenarios. This was done by calculating the rate of success and application, and the rate of success and non-application in percent for each label. The percentage of success and application and success and non-application was created by dividing the frequency of individual techniques, mandates and

relationships in the first scenario and second scenario respectively by their total frequency. For every label categories, median success percentages were established in order to compare them with each other and to ascertain which of them performed most successfully and was more related to application of the solution focused approach by the caregivers. It is to note, that for additional techniques that occurred less than ten times total, no percentages for success were computed, because percentages grounded on such few observation would be very susceptible to be based on chance and would have low informational value.

Furthermore, in order to ascertain in how many of the total reported situations at least one technique of each label categories was used, cross tabulations of each label category were calculated fragment by fragment and the obtained number of valid cases divided by the total number of fragments.

2.3.2 Perceived aspects preventing the successful implementation of SFS

Since the analysis of the first research question involved a careful study of the contents of the logbook fragments and the transcripts of interviews, most parts of the analysis for the second research question were conducted at the same time. In order to ascertain when caregivers found the solution focused approach not applicable or what reasons they provide as to why application was not attempted, the content of fragments and transcripts were scanned particularly for instances in which respondents made negative statements in regards to the fit of the approach. The transcripts of interviews were considered a principal source of information, since it was expected that caregivers would provide more opinions about the usability and reasons for non-application of SFS in general, as opposed to the logbook fragments, which were anticipated to be rather about describing individual circumstances of a reported situation. However, the descriptions of situations were also utilized to ascertain factors that caregivers hold responsible without explicitly naming them.

Key-phrases that were especially of interest in interviews, were statements like: “I could not work in a solution focused fashion in this particular situation, because…”, “Applying solution focused methods was not appropriate in this instance, due to the fact that…”, “My solution focused efforts were in vain, since…” or similar statements that made any references to perceived factors responsible for the futility of implementation attempts or to the perceived inappropriateness of the approach. Furthermore, queries of the interviewer addressing why the approach was not, or could not be employed, to which the interviewees provided a response, were also regarded as valuable.

For the analysis of descriptions of situations, the reason for not applying SFS or for the application failing was derived from the context of the situation. For instance, if a caregiver turned a client with a problem away, because he/she was with another client, it was ascertained that a lack of time was the reason for not engaging with the client in solution focused contact, and so forth. The caregiver does not explicitly mention the reason, but based on the rating the caregiver made on the four scenarios on the logbook form, and the description of the situation, it can be determined whether or not the caregiver perceived the situation to be a failed application of SFS or not, and what happened in the interaction that might contributed to the failure. Once the main reasons for not applying the solution focused approach were gathered, labels were devised that best described the most frequent ones and examples were selected from logbook entries that best illustrate each created label.

3. Results

The results that were obtained from the proceedings of the analysis, as described in the previous section, are subject of this part of this paper. In the following, findings will be disclosed individually for each research question, in order hitherto established.

3.1 Aspects of SFS most frequently used in situations perceived as successful

To answer the first research question, this section covers the frequency of applied labels for mandates, relationships and techniques and how those relate to the four scenarios of success and application of SFS. To start off by giving a general overview, the distribution of all provided fragments over the four scenarios shall be reviewed.

Out of all 153 fragments that were analyzed, 99 fragments, that is 64.7 percent or close to two-thirds of the total, were about instances in which SFS was reportedly successfully applied. On the other hand, only 6.5 percent of all caregiver experiences were about failed applications of the model, which constitutes the least often reported kind of interaction. The second most often reported scenario, which specified that solution focused methods were not employed, but the interaction was successful nonetheless, was reported in 30 or 19.6 percent of all cases. Provided experiences in which neither the application nor the interaction itself was perceived as successful were with 9.2 percent of all fragments the second least occurring. The distribution of fragments over the four scenarios and the skewedness towards the first scenario is illustrated in figure 1.

In the following, the results from relating the frequencies of labels for mandates, relationships and techniques of the framework and the additional label clusters to the four scenar-

ios will be disclosed. For that purpose, percentages of successful application of SFS and successful non-application will be reported for each variable, as well as for individual label categories as a whole.

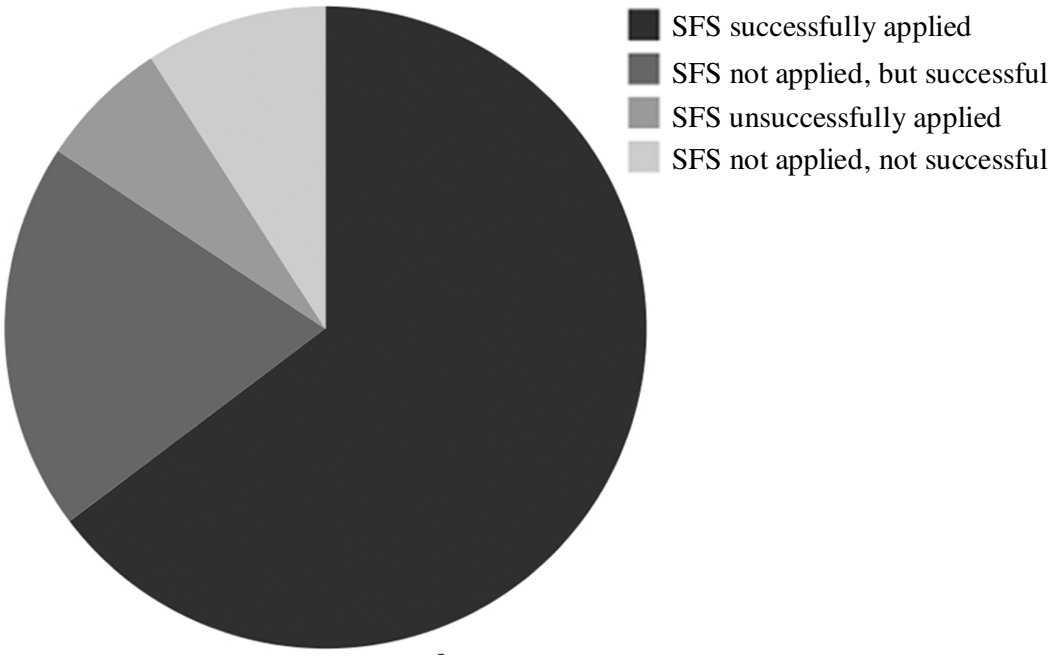

Figure 1. Pie chart of scenarios reported for 153 fragments provided by caregivers.

Mandates

The Coach was with almost 70 percent the mandate most emphasized by caregivers. When caregivers emphasized the coach, subsequent ratings of these interactions indicated to a large extend that SFS could successfully be applied and to a minor percentage that the situation was resolved successfully without the help of the approach. The second-most utilized mandate of the Leader however, showed an inverse relationship and was mainly successful in instances in which the approach was not used and rarely when solution focused practice was attempted. The Manager showed a low to moderate success rate for non-applications and moderate success rate for applying SFS successfully. An overview of these results is shown in Table 5.

Table 5

Frequencies of Mandates in Four Scenarios

Mandate	Scenario			
	Successfully applied	Successful non-application	Unsuccessfully applied	Unsuccessful non-application
Coach	95 (73.1%)	20 (15.4%)	9	6
Leader	7 (21.9%)	15 (46.9%)	3	7
Manager	15 (51.7%)	10 (34.5%)	0	4

Note. Percentages of perceived success of application and success of non-application for each mandate are shown in parentheses in column one and two respectively.

Relationships

With respect to relationships, all were mostly related to rating interactions with clients a successful application of SFS or at least a successful non-application. As shown in Table 6, the relationships lower in the *Flowchart* (See Appendix B), or towards the bottom of the Table, were progressively related to successfully applying solution focused practice. Therefore, the percentages of successful application are increasing from the Non-Committal Relation towards the Co-Expert Relation, as indicated in parentheses in the first column of Table 6.

Table 6

Frequencies of Relationships in Four Scenarios

Relationship	Scenario			
	Successfully applied	Successful non-application	Unsuccessfully applied	Unsuccessful non-application
Non-Committal	20 (40.8%)	16 (32.7%)	4	9
Searching	34 (61.9%)	12 (21.8%)	5	4
Consulting	31 (91.2%)	1 (2.9%)	1	1
Co-Expert	16 (100.0%)	0 (.0%)	0	0

Note. Percentages of perceived success of application and success of non-application for each relationship are shown in parentheses in column one and two respectively.

The percentages for perceived successful non-application, on the other hand, show an inverse relationship, in that they are increasing from the Co-Expert Relation towards the Non-Committal Relation, as shown in parentheses in column two of Table 6. Note that in no instances of a Co-Expert Relation which was reported, an interaction was characterized as a successful non-application. Also, the rate of success for the Non-Committal Relation is moderately low, disregarding whether or not application of SFS was employed. Concluding these findings, the relationships were all related with successfully interacting with clients, but applying the solution focused model was less prone to failure when caregivers could engage in relationships towards the Co-Expert Relation.

Solution Focused Techniques

In 54.2 percent of all reported caregiver experiences, solution focused techniques were employed. Also, as shown in Table 7, five of the eight techniques show moderately to very high rates of success in applying SFS, with Uncovering Resources and stimulating a Future Orientation even at and above 90 percent and Contextualizing, Goal-Setting and Giving Compliments at around 80 percent. This indicates, that chances were relatively high that an interaction was rated a success in terms of applying SFS when caregivers engaged in these techniques. At the same time, the percentage of successful non-application for these five techniques was at the very low end or even lacking completely. Furthermore, the techniques of referring to Exceptions, Differentiating and Socializing were comparably infrequently used, which is why no percentages for successes were computed. Nonetheless, it is noteworthy that interactions were to a large extend rated a successful application of SFS when these techniques were in fact employed.

In consideration of the techniques that met the cut-off criterion of minimal ten instances observed, the median of the percentage of successful application for this label category was 83.3 percent (SD = 5.7) and the median of the percentage for successful non-application was 8.3 percent (SD = 3.8). In conclusion, the techniques of the solution focused model are largely perceived as being beneficial for working in accordance with the solution-oriented approach and much less useful when opting for a non-solution focused alternative. Furthermore, the fact that three of the techniques were being used so scarcely, warrants speculating about factors that could explain this observation.

Table 7

Frequencies of Solution focused Techniques in Four Scenarios

Technique	Scenario			
	Successfully applied	Successful non-application	Unsuccessfully applied	Unsuccessful non-application
Contextualizing	28 (77.8%)	3 (8.3%)	1	4
Goal-Setting	29 (82.9%)	3 (8.6%)	3	0
Uncovering Resources	22 (91.7%)	1 (4.2%)	1	0
Future Orientation	9 (90.0%)	0 (.0%)	1	0
Giving Compliments	20 (83.3)	2 (8.3%)	1	1
Exceptions	4	1	1	0
Differentiate	6	0	1	0
Socializing	4	0	0	0

Note. Percentages of perceived success of application and success of non-application for each technique are shown in parentheses in column one and two respectively.

Conversational Techniques

Conversational Techniques were used in moderation, in 48.4 percent of reported cases. When these techniques were employed however, the interaction was mostly rated as a successful implementation of SFS, as indicated by the fairly high percentages for successful application in the parentheses of the first column of Table 8. The percentages of successful non-applications were for the majority of techniques at the very low end of the spectrum. Closed-Ended Questions showed somewhat deviating results, in that it was only moderately rated successful in instances in which solution focused practice was employed and the difference of rate in success between scenario one and two was not as significant for this technique as for the others. Also, it had the highest percentage of success in the non-application scenario, although still being well below 50 percent. The technique of Summarizing did not meet the criterion of 10 cases minimum and was therefore not considered when computing percentages of success.

Table 8

Frequencies of Conversational Techniques in Four Scenarios

Technique	Scenario			
	Successfully applied	Successful non-application	Unsuccessfully applied	Unsuccessful non-application
Active Listening	17 (89.5%)	1 (5.3%)	0	1
Open-Ended Questions	53 (88.3%)	4 (6.4%)	3	0
Closed-Ended Questions	7 (53.8%)	4 (30.8%)	1	1
Probing Questions	27 (79.4%)	2 (5.9%)	3	2
Summarizing	2	1	1	0

Note. Percentages of perceived success of application and success of non-application for each conversational technique are shown in parentheses in column one and two respectively.

Overall, the conversational techniques were generally related to bringing about favorable outcomes when caregivers interacted with a client in a solution focused fashion. The only exception to this was the technique of Closed-Ended Questions, which seem to be only successfully applicable with the solution focused approach in half of the situations they were employed and for which the rate of success when not applying SFS, was more than five times higher than for most other conversational techniques. The median of percentages for successful application of this label category was 83.9 percent (*SD* = 16.6) and for successful non-application 6.2 percent (*SD* = 12.5).

Techniques Involving Solution focused Thinking

Techniques involving solution focused thinking were employed in as much as 64.7 percent of all reported fragments. Furthermore, as indicated in column one of Table 9, five of the thirteen techniques show very high percentages of success and application in the eighties and nineties and very low ratings of success when caregivers did not used the solution focused approach. Two techniques of this cluster were merely moderately related to successfully applying SFS, while their percentage for successful non-application was not particularly conspicuous in comparison to remaining techniques. Four techniques (Looking Back, Postpone Question, Modeling and Offer Choice) were very rarely used. Therefore, they did not

Table 9

Frequencies for Techniques Involving Solution focused Thinking in Four Scenarios

Technique	Scenario			
	Successfully applied	Successful non-application	Unsuccessfully applied	Unsuccessful non-application
Challenge /Stimulate/Motivate	46 (90.2%)	2 (3.9%)	2	1
Empowerment	19 (95.0%)	0 (.0%)	1	0
Support Emotionally	17 (85.0%)	2 (10.0%)	1	0
Check Back with the Client	13 (72.2%)	4 (22.2%)	0	1
Adjust to the Level of Client	7 (43.8%)	3 (18.8%)	3	3
Refraining from Steering the Client	11 (84.6%)	1 (7.7%)	1	1
Show Understanding/ Compassion	11 (91.7%)	1 (8.3%)	0	0
Relieve/Not Overburden	5 (55.6%)	1 (11.1%)	3	0
Helping Remember	6 (75.0%)	2 (25.0%)	0	0
Other	16	1	1	2

Note. Percentages of perceived success of application and success of non-application for each technique are shown in parentheses in column one and two respectively. Techniques that did not meet the criterion of ten total cases are collectively denoted by 'Other'.

meet the criterion of minimal 10 cases and were collectively denoted as 'Others'. However, despite being used so infrequently, when these techniques were utilized alongside SFS, interactions were almost exclusively rated a success by caregivers. The median percentage of successfully applying SFS of the label cluster was 84.6 percent (*SD* = 17.4) and for successful non-application 10 percent (*SD* = 8.4).

Directive Techniques

In 62.1 percent of all experiences provided by caregivers, they used at least one technique that was situated in the directive cluster. In respect to the percentage of successfully

applying SFS, there was a great deal of variance between the techniques of this cluster. Most showed percentages in and around the midrange, while two were to a moderately high percentage related to successfully employing the solution focused model and comparatively little related to success of situations without using the model. Disregarding the variance, for the larger part of considered techniques, the rate of success when SFS was applied was higher than when it was not. However, three techniques were to a higher percentage related to success when SFS was not utilized, with the technique of Taking Over being the most effective in non-solution focused interactions and the least effective in solution focused contacts with clients (since there were none such instances reported by the caregivers). Also, three techniques were not described in a number of fragments high enough to meet the established criterion for calculating success percentages. Percentages of success are shown in Table 10.

Table 10

Frequencies for Directive Techniques in Four Scenarios

	Scenario			
Technique	Successfully applied	Successful non-application	Unsuccessfully applied	Unsuccessful non-application
Support Practically	28 (77.8%)	7 (19.4%)	0	1
Propose Solutions/ Give Tips	20 (57.1%)	7 (20.0%)	3	5
Provide Solutions	7 (26.9%)	13 (50.0%)	3	3
Clarify Context for Client	18 (78.3%)	4 (17.4%)	0	1
Taking Over	0 (.0%)	10 (62.5%)	1	5
Steering Client	4 (33.3%)	7 (58.3%)	0	1
Convincing	6 (60.0%)	3 (30.0%)	0	1
Give Opinion	3 (30.0%)	2 (20.0%)	2	3
Other	4	9	3	8

Note. Percentages of perceived success of application and success of non-application for each technique are shown in parentheses in column one and two respectively. Techniques that did not meet the criterion of ten total cases are collectively denoted by 'Other'.

The median of percentages of successfully applying SFS by using directive techniques was 45.2 percent (*SD* = 27.4) and of percentages for successful non-application of SFS 25 percent (*SD* = 19.1). These numbers indicate, that the techniques that were labeled as directive, tended to be perceived as to be somewhat incompatible with the intention to apply the solution focused model, although individual techniques seemed to differ in that regard to quite an extend (as indicated by a fairly large standard deviation).

Miscellaneous Techniques

Caregivers employed at least one of the six techniques in the miscellaneous cluster in 44.4 percent of all the described fragments. Out of the six techniques, four met the criterion of being applied at least ten times. As shown in Table 11, the distribution of reported usage of these techniques over both successful scenarios was relatively consistent, as their percentage of successful application was between just over 50 up to 75 percent and their percentage for successful non-application of SFS was between 16.7 and 26.1. This suggests that the techniques could be utilized moderately well by caregivers who tried to work with clients in a solution focused fashion. Also, the percentage of successes when working with these techniques and not practicing care by using SFS was not dramatically low, which could be an argument for the somewhat general character of miscellaneous techniques. Furthermore, since fragments, in which techniques of this label category were employed, tended to be rated a

Table 11

Frequencies of Miscellaneous/Neutral Techniques in Four Scenarios

Technique	Scenario			
	Successfully applied	Successful non-application	Unsuccessfully applied	Unsuccessful non-application
Clarify	26 (60.5%)	11 (25.6%)	2	4
Make Agreements	16 (69.6%)	6 (26.1%)	0	1
Interpreting Non-Verbal Cues	7 (53.8%)	3 (23.1%)	1	3
Visualize	9 (75.0%)	2 (16.7%)	1	0
Other	3	0	0	1

Note. Percentages of perceived success of application and success of non-application for each technique are shown in parentheses in column one and two respectively.

success, they seem to be of value in working with clients productively, which seem to be even more true for instances in which SFS is practiced. Overall, the median of percentages of success and application of SFS was 65.1 percent (*SD* = 9.4) and for successful interactions without engaging in SFS 24.4 percent (*SD* = 4.3), when techniques of this cluster were employed.

3.2 Perceived aspects preventing the successful application of SFS

In 54 logbook fragments, caregivers were not able to apply SFS successfully or opted against attempting to employ it. By scrutinizing these fragments, ten labels were created that best describe the reasons for non-application, failure in attempting to apply or interacting with the client altogether. Note that labels are not mutually exclusive in that sometimes a situation was reported which was best described by two or more labels, representing factors of the situation or the client that were perceived to prohibit using SFS. Five of the most frequently found labels were irrational/Anxious/Confused clients, Professional goals, Resistance, Time pressure and (Rule) Conflict. Further reasons that were less frequently encountered were: lacking internal communication, hostility in clients, intoxication of clients or the involvement of a third party in the process of care. In the following, the most frequently found reasons will be thoroughly explained and illustrated, and thereafter, additional reason will be described in short.

3.2.1 Irrational/Anxious/Confused Client

The most occurring reason that was found for not applying or failing to apply the solution focused approach was when the client was irrational in that he/she was upset or agitated, so that any attempt to apply SFS was seen as futile, or when a client was confused and could not comprehend what the caregiver was saying. Of fragments that were assigned with this label, three-fourths were about situations in which the caregivers chose a non-solution focused approach because of client-related factors and could successfully resolve the situation. To give an example, one caregiver wrote about an interaction with a client:

> "A client was talking incoherently. I gave the conversation more structure by summarizing and repeating what was said. By doing so I could calm the client down. I proposed a number of solutions and asked the client which of these he would like best. Solution focused practice is when you let the client think about solutions. In my opinion, he was not capable to do that in that moment and calmed down because I took over 'thinking' for him."[2](See 1.1, Appendix D)

[2] All translations of logbook fragments and interviews are by the author of this work.

The caregiver felt that in this state, the client could not engage in solution focused thinking and that taking a more directive approach could help the client regain clarity. The idea that applying solution focused methods would not work when clients are upset, uneasy or confused was expressed by several caregivers in multiple logbook entries. In one fragment in which a client was very upset because of a reorganization of the location, one caregiver even remarked that applying the solution focused approach was "[…] not possible […]" (1.2, Appendix D) in this situation. In the majority of the cases when this label was applicable, caregivers did not try to utilize solution focused strategies but opted for a more directive approach, because they were convinced that SFS would not work in these situations. In the remaining three cases that were described by the label of this category, caregivers tried to apply SFS but failed. For instance, one logbook fragment was about a client who was confused and the caregiver tried to clear things up by explaining and making sketches on paper. When this did not work, the caregiver chose to provide the solution because, as she mentioned in the entry, "[…] the client was not able to participate in thinking about a solution [in this state]" (1.3, Appendix D). The main reason that was almost consistently pointed out by caregivers for not employing SFS was that clients could not contribute to the solution when they were irrational, because they were too upset to think or comprehend in this state.

3.2.2 Professional Goals

This label category involves occasions in which caregivers chose an alternative to solution focused practice, based on their goals or convictions as professionals. This is why no experiences of failed implementation attempts were labeled in this category, but only fragments about, for the most part, successful non-applications, and fragments about failed non-applications. The instances reported, in which participants wrote that they used a non-solution focused approach to success, were exclusively about interactions in which caregivers consciously chose to make decisions for the client, because they were convinced that these would bear beneficial consequences for him/her. For example, a caregiver, together with the nursing staff, changed the layout of the recreational room so that a client, who generally tended to stay to herself, would become more involved with other clients. Or in another fragment, a caregiver describes that she arranged for an appointment with a therapist for the client, without acquiring consent beforehand.

In three fragments to which the label of this category applied, the caregivers chose an alternative to SFS but to no success. In two of these, the caregiver remarked that the client either did respond to application attempts of SFS, by taking a passive stance and negating the

problem. This, stated the caregiver, did render taking a solution focused approach unviable. Furthermore, the caregiver remarked that the client did not have a request for help, which also ruled out the implementation of SFS. In another example, the caregiver dealt with a client in a very stern fashion. She gave the client "[…] no room to express his wishes […]" and told him: "[…] that's how it is and if you don't like it, you can't live here.". She added: "I don't know the client well enough to know his request for help and through the approach I chose, the client doesn't get the chance to express his wishes in regards to important things." (1.4, Appendix D). The caregiver justified her choice for this approach by saying that the she looked up information from previous care and found that the client is a very dominant man who has a need for structure and that a directive approach would meet that need. In all fragments that were described by the label of the category, the caregivers did not consider engaging in SFS, or they found that a solution-oriented approach would not fit the situation and that the option they chose instead would benefit the client.

3.2.3 Resistance

The label Resistance represents reported situations in which the client intentionally or unintentionally resisted care or negated the caregivers. There was one situation encountered in which the caregiver opted successfully for a non-solution focused alternative and six others from which one half were occasions of failed implementation attempts and the other half about instances in which SFS was neither attempted nor the situation deemed a success. Of these, especially the ones in which the interaction failed are of interest, since it could be argued about whether SFS was indeed employed in the fragment that was characterized as a successful non-application of SFS. In situations in which the implementation of SFS failed, the clients reportedly did not respond to solution focused methods and caregivers were at a loss on what to do. To exemplify, a caregiver wrote about a client he visits two times a week and who is contempt with how things are. The caregiver noted that the client is "[not able] to come up with possible solutions himself and that this is so exhausting for him that he never tries." (1.5, Appendix D). Therefore, the caregiver felt, every attempt to use SFS was in vain with this client. Adding to this, the lack of success was reportedly very demotivating for the caregiver and he was very desperate on what to do about the situation. In the remaining fragments to which the label of Resistance applied, caregivers judged a directive, non-solution focused approach more appropriate, but could not resolve the situation.

Overall, caregivers had difficulties with clients that did not responded cooperatively or receptively to attempts to engage in solution focused interactions, and either reacted by altering their approach to more directive methods, or found themselves in a quandary and were at a loss on how to proceed.

3.2.4 Time Pressure

Another very frequently encountered reason why caregivers found a successful implementation of SFS to be obstructed was the lack of time to prepare for a client-interaction, or shortage of time to engage with a client in a solution focused way. In two reported instances, caregivers kept trying to apply SFS in conversations with clients, but they found that it took the clients too long to come up with solutions, so they took over and provided answers themselves. The time the clients needed that was perceived as too long differed between both situations, one being ten minutes and the other two hours. Furthermore, it is to note that little information was provided on what exactly was attempted on the caregivers' side in occasions in which clients were unable to come up with solutions. Other described situations in which time was seen as the deciding factor were similar, either the caregivers found clients to be too slow in coming up with own solutions due to being verbally weak or not knowing how to do it, or the caregivers had a full agenda and little time to spare on trying to apply SFS on the spot.

3.2.5 (Rule) Conflict

This label category encompasses reported experiences in which the reason for not applying SFS successfully was wholly or partly determined to be either about the violation of rules, which was encountered one time, or a conflict between caregiver or staff and the client, which was described in two fragments. In occasions in which there was a conflict present, there was thought to be resistance to reception of care on part of the clients as well, thus these fragments were described by the label (Rule) Conflict and Resistance. This distinction into two labels was made because resistance to care was found to be not always related to conflict, but could refer to a lack of receptiveness to SFS in clients in that they did not respond favorably to solution focused methods. In any case, in conflict situations caregivers did not succeed in implementing solution focused practice and switched to more directive means. As mentioned, there was one time in which the use of SFS was not attempted due to the violation of rules. In the respective logbook fragment, the caregiver wrote about an incident in which a client disrupted an ongoing counseling session to which the caregiver reacted with irritation.

It then turned out, that the client had violated the rule to wait her turn only because she had wet herself and did not know how to help herself. The caregiver reflected in her logbook: "I should have asked her what was so urgent that it could not wait before judging her preemptively." (1.6, Appendix D). Therefore, in this fragment the caregiver acknowledges that she reacted in the heat of the moment and that the chosen approach was not appropriate. In caregiver-client interactions that were assigned the label of (Rule) Conflict, the caregivers relied on directive means, when there was a conflict present and in a confronting way when violation of a rule was the case.

3.2.6 Additional reasons

Further reasons found for not succeeding in applying SFS, or opting for a different approach were: the lacking internal communication, hostility in clients, intoxication of clients or the involvement of a third party in the process of care.

Lacking internal communication was found to be an issue in two caregiver reports and had severe consequences in one of these. Problems arose when caregiver were not informed and did not share information about the clients and their schedule. Resulting misunderstandings and ambiguities of responsibilities demolished perceived opportunities to apply SFS and even worse, had negative consequences on the well-being of the client.

Hostility in clients towards the caregiver was perceived as a reason to not engage in SFS in three caregiver fragments. In those instances, caregivers reacted exclusively in an assertive manner and chose against attempting to apply SFS. Furthermore, this label always co-occurred either with irrationality, resistance or intoxication in clients.

When clients were intoxicated with alcohol (or sometimes drugs, as one caregiver noted), the application of solution focused practice was always perceived inappropriate. Moreover, intoxication is often accompanied by irrationality and sometimes hostility, which makes dealing with a client in that state especially difficult. Whatever the case, when caregivers had to interact with a client under influence, they did not attempt to employ the solution focused model, but instead relied on assuming a directive stance and referring to regulations at Aveleijn pertaining drug and alcohol use.

The involvement of a stake-holding third party, such as the family, did arguably get in the way of the implementation of SFS in one reported caregiver experience. The client did not want to continue his speech therapy, but the caregiver as well as the client's family deemed the treatment very important. Although there was also a divergence present between profess-

sional goals and the client's goals, the fact that the third party got involved and backed up the view of the caregiver could have been a factor, since the clients position lost emphasis in this constellation.

It should be noted that, in as many cases as there was the most occurring reason of an irrational, upset or anxious client found for not engaging in SFS, a reason was indiscernible from the caregiver accounts. This means that caregivers very frequently omitted an explanation for not applying SFS, for not contemplating it, or as to why the application did not succeed. To ascertain the actual reasons the caregivers perceived why the solution focused approach could not be employed successfully, was impractical without resorting to downright speculation. Also, the sheer number of fragments to which each reason was found to be valid, is no indication for their significance, meaning reasons for non-application which represent only few or a singular fragments, could be of importance as well. Thus, reasons that were encountered to a lesser extend may hold vital information as well, on how to make the approach more applicable for caregivers new to SFS.

4. Discussion

This study provides some insights into the experiences of professionals working with a solution focused model in caring for people with ID, by studying logbook entries that were created biweekly over the course of one year. As it was mentioned in the introductory segment of this work, not much research has been conducted on the use of solution focused methods on people with ID that rely on sustained care. Furthermore, to the knowledge of the author, this study was the first to focus on the experiences of learning caregivers in learning to use SFS effectively with this population, and obtained results could therefore be used to inspire prospective advancements in the training of practitioners to apply the solution focused approach and serve as a source of information for future research conducted on the subject. However, before further discussing implications and limitations of the study in general, individual findings will be discussed, as well as potential explanations that may have caused or influenced these and what could be gathered that might be useful to the field.

4.1 Reviewing the findings

There were a number of interesting findings in this study, one of the most striking becoming apparent when reviewing the results of the caregiver ratings on fragments about the success of interactions and whether or not SFS was applied: Almost two thirds of the situations described by participants were about working experiences in which they were able to

successfully use the solution focused approach, and nearly 20 percent were about at least successful interactions without the use of the approach. This adds up to a success rate of 84.3 percent overall in working with clients. When considering the subject at the core of this study, the perceived applicability and success of SFS when working with people with ID, it is to note as a positive, that caregivers deemed an abundance of reported situations a success and a major share of these a successful implementations of solution focused practice. This indicates not only, that caregivers were aptly learning and applying the model to a multitude of situations, but also supplements the notion that solution focused practice is a good fit for the context of caring for people with ID (Roeden et al., 2011).

4.1.1 The utilization of solution Focused and non-solution focused aspects

The results of the first research question have shown that participants were, to a large extend, able to take advantage of most aspects of the solution focused model as represented on respective sides of Cauffman's SolutionCube, although, not all aspects were used equally often and to the same success. Pertaining to the mandates, caregivers had a clear preference for the Coach, which was also the most emphasized in situations reported successful applications of SFS. However, the mandates of the Manager and especially the Leader were far less associated with productively employing the model, which bears the question what might be responsible for this. One thing to consider is, that the use of mandates is not clear-cut in that one choses the one over the other, but rather an emphasis for one mandate, whilst still regarding the others to an extend fitting to the respective situation (Cauffman, 2010). Seeing that generally not many instances were reported by the participants in which they failed to succeed in an interaction with a client, less emphases on the Manager and the Leader does not necessarily have to be understood as a failure to recognize these mandates. Instead, this may reflect a bias towards the Coach combined with a foggy conception of these mandates and SFS in general. For example, when caregivers reported to have emphasized the Leader, they reported few instances in which the implementation of SFS was successful, but even less in which it failed. The same goes for the Manager. The amount of times implementation was indicated a success contrasted with the times implementation failed was still quite high, in fact for the manager implementation of SFS never failed when tried. Also, and especially for the Leader, the relatively high rate of situations in which the interactions were regarded as successful non-applications has to be considered as well. In the Leader and the Manager, caregivers have to engage in a more active and directive role which could arguably be understood as a contradiction of the solution focused idea. It is possible that caregivers felt that the role that is associat-

ed with these mandates is mutually exclusive with applying the approach and could have contributed to the comparably high amount of fragments in which these mandates were emphasized, that were rated non-applications.

The results on relationships of the solution focused model that were engaged in showed a preference of participants for some over others as well. Caregivers reported more interactions with clients to be relationships at the higher end of the flowchart on Cauffman's cube, thus as Searching or Non-Committal Relations, and comparably less as Consulting and Co-Expert Relations. The relationship between the client and the caregiver is determined to a large extend by the client, the client's situation, and his/her perception of the problem and personal ways to solve it. So the client expresses his/her needs (or he/she does not), depending on the stage he/she is at towards optimal solution focused functioning, and the caregiver ideally acknowledges the needs by acting in accordance with the relationship that fits the client's state. Therefore, the supposed preference of caregivers to engage in a Non-Committal or Searching Relation is actually defined by the individuals of the population the caregivers are working with and frequency alone has little informative value. However, results did show as well, that caregivers rated situations in which there were relationships towards the Co-Expert Relation and away from the Non-Committal Relation, to a much higher percentage successful applications of SFS, while the rate of non-application decreased together with the amounts of failed interactions. This suggests that the caregivers' capability to efficiently support the client by using means of the model, increased with the client's level of self-efficacy and solution focused functioning. This is consistent with the rate of successes in application found for the more passive mandate Coach and techniques that are less directive in style, because these also involve emphasizing the agency of the client, and assuming a less active role on side of the caregiver.

When reviewing the results on the categories of techniques in regards to their rate of success of application of SFS, it becomes apparent that the techniques that are part of the model and the conversational techniques that are taught at Aveleijn, are in the majority of cases perceived as effectively applicable in conjunction with the solution focused approach. This is reflected in the percentages of situations, in which these were used, that were rated successful applications of SFS, which were almost exclusively around 80 percent with a low amount of variation. These findings seem intuitive, since the use of techniques affiliated with the solution focused model constitute the implementation of the approach itself, and techniques are expected to be compatible with each other in the quest of promoting solution-oriented functioning. Nonetheless, the high percentage of perceived successful applications of

solution focused techniques also proposes that caregivers seem to be quite able to effectively incorporate different aspects of SFS and employ these in the field. Furthermore, caregivers did utilize numerous techniques that are not part of the solution focused model, but involve thinking and acting in accordance with it, with mostly positive outcomes. This could be taken as an indication that caregivers expand their understanding of solution focused practice beyond the immediate theoretical conceptualization, a possibility in line with the fundamental idea of the systemic model of being a stance or mindset rather than a set of methods and techniques (Connie & Metcalf, 2009).

One additional point that needs to be raised is the encountered scarceness of application of some techniques that are part of the solution focused model and of some conversational techniques. Out of all solution focused techniques, Socializing, pointing out exceptions to the client and applying differentiations were utilized only 17 times combined, and Socializing alone made up mere four of these applications. Disregarding the relatively clearly defined criteria for this label to be scored, the technique may have been encountered so infrequently, because it is about interacting with the client to foster a trusting relationship, and therefore, its implementation comprises various verbal and non-verbal behaviors. Since discerning partially implicit and non-verbal acts by studying written accounts seems rather incongruous, this element may have been used more often than it appears in the results and was simply not acknowledged due to the operationalization of this study.

In respect to the rare use of the technique Differentiate, in two of the total seven times the technique was employed, caregivers maintained that differentiating means applying a scaling question, which is just one way to achieve differentiation. The scaling question entails asking clients to rate two states on a scale from 0 to 10 (zero being worst and ten being best), such as the state they were in at the beginning of counseling and the state they are in now. As one caregiver remarked, applying the scaling question on people with ID may sometimes be difficult, because not all clients are able to count up to ten and understand the concept of equidistant scales. This could explain why this technique was almost exclusively used when caregivers made assignments for supervision, which demand that all aspects of SFS are to be applied in an interaction that is captured on video. Coming back to the utilization of the technique Differentiate, the lacking use may be due to a perceived requirement to rigidly adhere the theory of SFS in that caregivers might feel compelled to employ the scaling question in order to achieve differentiation, as they exercise it in training situations, without adjusting their approach to the immediate situation. This is a pitfall that Nylund and Corsiglia (in Cu-

nanan & McCollum, 2008) cautioned against by referring to this way of inflexibly using the model as 'solution forced'.

Although not all caregivers found these techniques problematic, differentiating and the scaling question, and how to naturally apply it to this population, seems to be unclear for some. Therefore, it might be important to improve upon the way this aspect of the approach is taught to practitioners intending to learn SFS.

The Exception technique was very uncommonly applied as well. Only six times total caregivers reported that they made use of it. In fragments in which this technique occurred, caregivers asked the client explicitly or implicitly how they solved a particular problem in the past or without the availability of extraneous support. The reason why Exceptions were so rarely encountered may be due to the criteria established for labeling the technique during analysis. Exception is defined as one way to point out resources to the client, which is an distinctive, but related aspect of the 7 Step Dance itself. Since the technique of Uncovering Resources was employed incomparably more often than Exceptions, the low number of encountering the latter might be due to an overlap in operationalization between the two, meaning that the researcher may have sometimes decided to label Uncovering Resources over Exceptions because both techniques are somewhat of the same category. It is difficult to discern whether the cause for the frequency of this technique is due to a lack of operationalization, or due to caregivers not knowing how to apply Exceptions.

For the less frequently used techniques, one should also take in consideration, that applying these might have been not required since there may have been no client-interactions in which applying these were appropriate. Whatever the case, future research on solution focused support with a comparable population, should be sensitive to the perceived applicability of the three, less frequently applied techniques of the model.

For the additional label clusters that were created, there are some points to be made in regards to directive techniques and the use of SFS. The fact that caregivers resorted to directive techniques in 62.1 percent of all described fragments, and seeing that caregivers reported that they could only successfully engage with the client in a solution focused way in less than half of the times these techniques were employed, could suggest that some caregivers might not feel confident in handling some situations by the use of solution focused means, and perceived more directive practices as more appropriate. This was further underlined by already discussed results on relationships and mandates involving a directive, more active role of the caregiver, since these aspects of SFS were related to a lesser extend to perceived successful applications of SFS as well. While alternative explanations have been partially dis-

cussed for mandates and relationships, taken together, these results support the suggestion that some caregivers may have had, to some degree, difficulties when clients did not fully collaborate or lacked initiative. This proposition is substantiated by findings on the second research question, which will be discussed in the following.

4.1.2 Obstacles in practicing solution focused support

Although, the majority of provided caregiver experiences were rated successful applications of the solution focused model, there were some in which implementation was reportedly not successful or opted against. A large margin of the reasons found, that were perceived as rendering the implementation of the solution focused model invalid, involved the client being reportedly not willing or not able to collaborate with an approach chosen by the caregiver, or some kind of conflict or difference in viewpoints between the two parties. For instance, when the client was confused or overly anxious, the caregivers found that clients could not participate in solution focused thinking and that switching to a directive approach to do the thinking for them would be necessary. These situations belonged to the most reported in which SFS was seen as not appropriate. Nonetheless, an important differentiation should be made in regards to fragments commended with this label: Caregivers often employed conversational techniques such as summarizing and clarifying the circumstances for the client to help the client to structure his/her thoughts and regain composure and due to the fact that they took over the conversation in doing so, the interaction was frequently rated non-solution focused. However, acknowledging the client's need for clarity and considering his/her mental and emotional state is in line with basic notions of the solution focused model of client-centeredness and doing what works and sharing it with the client. Also, taking an active role in an interaction does not preclude acting in a solution focused fashion, but is covered by the mandate of the Leader, which underlines the aforementioned difficulties caregivers sometimes had with the more directive aspects of SFS. Caregiver accounts on situations in which they took over a conversation by providing a solution to the issue at hand, because the clients were seen as being too irrational to devise a resolution themselves and SFS being impossible in those instances, are to be distinguished from the former discussed interactions in which caregivers merely assisted clients in calming down, in that the former are non-solution focused.

An additional, very frequently reported reason for not employing SFS, which also involved noncooperation on the side of the client, was resistance and conflict between caregivers and clients, or conflict in rules, which both were often paired with resistance. The mandate of the Leader seems highly appropriate in these situations and, therefore, the difficulties of

some caregivers to put this mandate to use may be partially responsible for the perceived inapplicability. Also, de Shazer et al. state in regards to resistance, that it is a natural reaction to protect oneself and could just reflect the client's preference to be cautious (2007), which caregivers should consider when judging the applicability of SFS. Furthermore, Shazer et al. maintain, that the solution focused model is always applicable and that none-responsiveness or resistance of the client demands adjusting one's approach to what works for the him/her (2007). When considering these points, it might be beneficial to allocate more attention to flexibility and patience in application when training practitioners in SFS.

Time was found to be an additional important aspect, entering the decision whether or not to engage in SFS. In some caregiver reports, clients either were reportedly to slow in coming up with a solution, or the caregiver was short on time due other responsibilities and, therefore, deemed the application of SFS not fitting. For the former scenario, there was very little information in the accounts of caregivers about what they did to help the client. However, since clients did not seem to respond to the chosen approach in these situations, adjustments to the intervention would have been merited, which once again, highlights that some caregivers found it sometimes difficult to tailor practice to the individual client. For the latter scenario, one needs to remember that caregivers that participated in this study were still relatively inexperienced with the approach and, as de Shazer himself cautioned, the solution focused model has some experience-dependence to it (in Trepper et al., 2006), in that it takes a long time of practice until application is flexible and expert. However, any approach is deliberate and time consuming for beginning practitioners but becomes steadily more effortless and quickly to use with increasing experience. For that reason, the factor of time should not be seen as a serious impeding factor, but should be kept in mind by learning caregivers and supervisors. Therefore, caregivers should be reminded that proficiency comes with practice and supervisors should encourage them to keep at it, even when time is a scarce commodity.

Third-party and professional goals were found to be reasons as well for not applying SFS in some caregiver experiences. This suggests that it was sometimes perceived inappropriate to put the client in the center of the caregiving process, especially when caregivers held certain professional goals that were not in line with the wishes of the client. It is important to consider that caregivers have a responsibility to act in accordance with their professional opinion on what benefits the well-being of the clients. However, in the fragments in which divergent professional goals were seen as a reason to not engage in SFS, caregivers mostly negated the client altogether and made decisions for the client without consulting him/her beforehand, and in many cases without contemplating the use of SFS.

These results show, that it may be expedient to address this issue in future revisions of trainings of SFS, by showing that complying with own professional convictions and regarding the autonomy of clients are no mutual exclusives, and can be accommodated in practicing care with the solution focused model.

Results also showed that lacking internal communication can have particularly adverse consequences. This is intelligible since people with ID often have a heightened need for clearly structured communication and routines (World Psychiatric Organization, 1999), which was also often the subject of reported caregiver-client interactions. Ambiguities and misunderstandings on side of the staff caring for clients, corollary counteracts the fulfillment of aforementioned need, which points out the importance of well-coordinated and communicated cooperation between professionals intending to put the solution focused model to use with people this population.

For instances in which a reason for not applying SFS was unascertainable, there is a lot of room for speculation why caregivers did not employ the model. It is a possibility that caregivers habitually followed their intuition and did not consider using SFS because of its subjective novelty. Also, as Smith (2011) found out for practitioners learning SFT, they sometimes 'slip back' into old ways or do not consider solution focused methods to be appropriate in some situations and therefore stop attempting implementation altogether. This might also be applicable to practitioners learning to apply SFS. An additional factor could be the lack of information in some logbook entries, meaning, that caregivers may have had a motivation for choosing an alternative approach, but omitted it in their report.

Finally, intoxication in clients, particularly by alcohol and drug abuse, and especially when paired with hostility, was seen as a reason to rely on non-solution focused, more directive approaches. Possible explanations as to why implementation was not seen as viable in those instances are threefold: Firstly, dealing with an intoxicated client involves dealing with an irrational, erratic client, which makes it more difficult to use solution focused means and to emphasize and rely on client contributions, especially for inexperienced caregivers. Secondly, when hostile, intoxicated clients are aggressive, caregivers might understandably be concerned for their own safety, which would impede endeavors to arduously employ SFS and favor switching to an approach more familiar. Thirdly, since drug and alcohol abuse is a prevalent problem in people with ID (Slayter, 2008), there are protocols in place at Aveleijn on how to proceed such cases. Acting in adherence of these regulations logically entails narrowing one's scope of action and the option to engage in solution focused practice might have been overshadowed by the perceived authoritative significance of aforementioned regulations.

Despite the numerous informative findings this study has provided, there are several points to be made in respect to limitations of generalizability and shortcomings in operationalization that should be regarded in future research, subjects which will be discussed in the next segment below.

4.2 Limitations

Due to the mainly descriptive and partially exploratory nature of this study, several limitations need to be disclosed. First off, convenience sampling was employed to recruit participants and the sample size was rather small. Therefore, generalizations to the population of caregivers at Aveleijn at large are not feasible. Furthermore, respective participants provided a differing amount fragments, meaning some recorded a working experience every two weeks for the full twelve months, while others reported merely eight fragments in total. This led to skewedness in the degree to which individual participants are represented in the data, which needs to be considered in the interpretation of the results. Also, since each caregiver attends to a limited number of clients with distinct problems and dispositions, reported experiences of individual caregivers were often about the very same client and a reoccurring subject. Together with the overrepresentation of some caregivers in the data, this led to an overrepresentation of particular cases as well, which was not considered in the operationalization of this research. Future research on the subject would be advised to use a randomized sampling method and a larger sample size, and ensure, by prompting or by use of incentives, that participants provide an experience from practice regularly, so that representative and generalizable results may be obtained.

The fact that the vast majority of caregiver experiences were reportedly successful applications of solution focused practice, could be seen as an indication that caregivers were able to employ the approach productively for the most part. However, due to the conceptualization of the logbook template (see Appendix A), the possibility remains that the frequency of successful applications was produced by a bias in caregivers towards favoring reporting their successful experiences with the model instead of their failures. Participants were asked to periodically provide an example that applies to one of the four scenarios: successful application of SFS, unsuccessful application of SFS, successful non-application or unsuccessful non-application. The participants might have wanted to ‘do well’ because they were aware of the subject of the study and, since they had the option to freely choose what kind of experience to deliver, they may have tended to report client interactions of the first scenario. This concern could be circumvented in future research endeavors, by requesting examples from

practice for each of the four scenarios from the caregivers. This would arguably diminish the problem of response bias, since participants would not have to choose one single experience to report out of a two week period of practice.

An additional problem that can be tracked back to the way the logbook template was set up was the variance in detail of fragments that different participants provided. Some caregivers described situations exhaustively by naming every technique used, while others restricted their accounts to one-line statements. That opened the process of analyzing the fragments up to subjectivity and interpretation, since caregiver behavior often had to be derived from the context of the logbook entries. The author of this work advises that prospective studies provide information on the logbook template about the expected comprehensiveness of caregiver report. Including a minimum and a maximum for the expected length of caregiver descriptions could be also advantageous.

Furthermore, in regards to the logbook template, there was some ambiguity in respect to the wording of scenario three (see Appendix A): this scenario was characterized by not having employed SFS although having felt that it would have been possible. A large part of participants understood this scenario to entail not having employed SFS and the interaction being successful. Therefore, this understanding was consequently used for the third scenario in the analysis of the first research question of this study, whilst the ratings on success and application on some fragments were corrected if they deviated from the described content. Nonetheless, the fact that the meaning of the scenario was not explicit for every participant may very well have lowered the reliability of the characterization of individual fragments as successful or unsuccessful, which should be considered regarding the results on research question one.

The pilot study, which was conducted in the preparatory stage for the main analysis, showed that there was a substantial lack of inter-rater agreement, which suggests a considerable degree of subjectivity involved. Although, criteria for the labeling process and definitions of individual labels were subsequently discussed in great detail, it is presumable that some degree of subjectivity remained in the main analysis, which may have influenced consequent results. In anticipation of this problem, future studies should incorporate pilot studies with a larger panel of raters to establish a better understanding on used labels and to ensure reliable results.

For the analysis of the first research question, the frequency of individual techniques and aspects of the solution focused model were related to the caregivers' appraisal on the effectiveness and whether or not SFS was used in the situations in which these were encoun-

tered in. Since the established relationships were merely correlational and individual aspects of SFS were used in conjunction, contributions of single techniques were indiscernible and no claims can be made pertaining causation. One suggestion on how to rectify this shortcoming could be to include participants' perceived effectiveness of utilized techniques and aspects in the logbook template.

On a more general note, over the course of the analysis it became apparent that the conception of what constitutes solution focused practice and when it is successful, often varied between and within participants. Thus, the reliability of caregiver responses on when SFS was successfully employed in an interaction was somewhat compromised. This ambiguity in conceptualization is a problem that applies to the solution focused approach on a general level and especially to adaptations to clinical practice (Cunanan, & McCollum, 2006). Since a clear outline and differentiation of one approach from another is a vital prerequisite for ascertaining and safeguarding its efficacy and applicability, a clear definition of SFS in clinical terms ought to be established. For the time being, the author cautions the reader to be aware of this obscurity.

4.3 In closing

Despite the limitations, the results that were obtained in this study are valuable sources of information for future research on the applicability of solution focused support on populations with intellectual deficiencies. This means that they could serve as an inspiration and reference in guiding these prospective endeavors towards areas of solution focused practice that are in need of exploration. It has been indicated, that caregivers that are learning to work with the solution focused approach were for a large majority able to utilize its elements effectively with clients, while some tended to have difficulties putting to use a few aspects of the model. Furthermore, in certain situations, some practitioners seemingly found it more difficult to use solution focused means and were inclined to rely on alternative, mostly directive approaches that are rather related to the traditional expert-role of the caregiving profession.

These findings should be understood as a first step of, hopefully, an abundance of research to come on the application of the solution focused model on the context of sustained care for people with ID. Future studies need to be carried out to substantiate the results of this work and to further investigate factors facilitating or impeding the success in employing solution focused support. Finally, this work corroborates the notion of solution focused support being a good fit for clients with ID and underpins that efforts to apply and refine the approach in this context is merited.

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Appendices

Appendix A

Dutch Version (original):

Dagboek-Template

Vraag 1:

Bent u de afgelopen 2 weken bewust bezig geweest met het toepassen van Oplossingsgericht Werken?

JA / NEE (doorhalen wat niet van toepassing is)

Vraag 2:

Kies 1 van de hieronder beschreven 4 momenten.

a) Kun je dit moment beschrijven; wat gebeurde er precies, wat waren de omstandigheden?
b) Kun je beschrijven wat je op dat moment gedaan hebt.

4 Momenten	*Op dit specifieke moment had ik het gevoel dat ik Oplossingsgericht Werken effectief kon toepassen*	*Op dit specifieke moment had ik het gevoel dat ik Oplossingsgericht Werken niet effectief kon toepassen*
Op dat moment heb ik OGW toegepast	**1**	**2**
Op dat moment heb ik OGW niet toegepast	**3**	**4**

Moment dat ik kies → nr:

Omschrijving van het moment en wat ik heb gedaan:

.....
.....
.....
.....

Vraag 3:

Onderstaande uitspraken hebben betrekking op hoe u uw werk beleeft en hoe u zich daarbij voelt. Wilt bij iedere uitspraak aangeven hoe vaak deze van toepassing is geweest op u in de afgelopen 2 weken?

Dit kan door steeds het **best passende** cijfer (van 0 tot 6) in te vullen.

0 = nooit
1 = sporadisch
2 = af en toe
3 = regelmatig
4 = dikwijls
5 = zeer dikwijls
6 = altijd

1. Op mijn werk bruis ik van energie. 0 1 2 3 4 5 6
2. Ik vind het werk dat ik doe nuttig en zinvol. 0 1 2 3 4 5 6
3. Als ik aan het werk ben, dan vliegt de tijd voorbij. 0 1 2 3 4 5 6
4. Als ik werk voel ik me fit en sterk. 0 1 2 3 4 5 6
5. Ik ben enthousiast over mijn baan. 0 1 2 3 4 5 6
6. Als ik werk vergeet ik alle andere dingen om me heen. 0 1 2 3 4 5 6
7. Mijn werk inspireert mij. 0 1 2 3 4 5 6
8. Als ik 's morgens opsta heb ik zin om aan het werk te gaan. 0 1 2 3 4 5 6
9. Wanneer ik heel intensief aan het werk ben, voel ik mij gelukkig. 0 1 2 3 4 5 6
10. Ik ben trots op het werk dat ik doe. 0 1 2 3 4 5 6
11. Ik ga helemaal op in mijn werk. 0 1 2 3 4 5 6
12. Als ik aan het werk ben, dan kan ik heel lang doorgaan. 0 1 2 3 4 5 6
13. Mijn werk is voor mij een uitdaging. 0 1 2 3 4 5 6
14. Mijn werk brengt mij in vervoering. 0 1 2 3 4 5 6
15. Op mijn werk beschik ik over een grote mentale (geestelijke) veerkracht. 0 1 2 3 4 5 6
16. Ik kan me moeilijk van mijn werk losmaken. 0 1 2 3 4 5 6
17. Op mijn werk zet ik altijd door, ook als het tegenzit. 0 1 2 3 4 5 6

Hartelijk dank voor uw inzet!

English Translation:

Logbook Template

Question 1:

Did you consciously apply solution focused practice in the last two weeks?

YES / NO (cross out which does not apply)

Question 2:

Chose 1 of four scenarios described below.

a) Could you describe your scenario; what happened exactly, what were the circumstances?
b) Could you describe what you did in that scenario?

4 Scenarios	*I felt that I could apply SFS in this particular situation*	*I felt that I could <u>not</u> apply SFS in this particular situation*
I did apply SFS in this situation	**1**	**2**
I did <u>not</u> apply SFS in this situation	**3**	**4**

I choose scenario → nr:

Description of the situation and what I did in that moment:

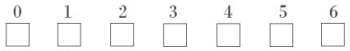
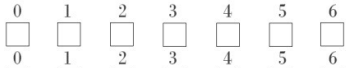
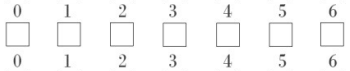
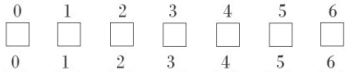
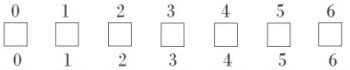
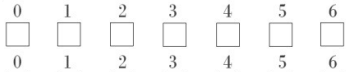
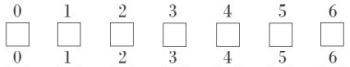
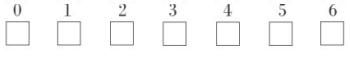
.....
.....
.....
.....

Question 3:

The statements below are about how you experience your work and how you feel when you at work. Would you indicate for each statement how frequently it applied to you in the past two weeks?

Please indicate a number that **fits best** (from 0 to 6)

0 = never
1 = sporadic
2 = now and then
3 = regularly
4 = often
5 = very often
6 = always

1. I'm brimming with energy when I'm at work. 
2. I find my work useful and meaningful. 
3. Time flies when I'm at work. 
4. I feel fit and strong when I'm at work. 
5. I am excited about my work. 
6. I forget everything around me when I'm working. 
7. I feel inspired by my work. 
8. When I get up in the morning, I look forward to go to work. 
9. When I'm engrossed in my work I feel happy. 
10. I am proud of the work I do. 
11. I get carried away by my work. 
12. When I am working I can keep at it for a long time. 
13. I see my work as a challenge. 
14. I find my work pleasing. 
15. At work I have a lot of mental resilience. 
16. I find it hard to get away from my work. 
17. At work, I always persevere, even if it gets tough. 

Thank you very much for your commitment!

Appendix B

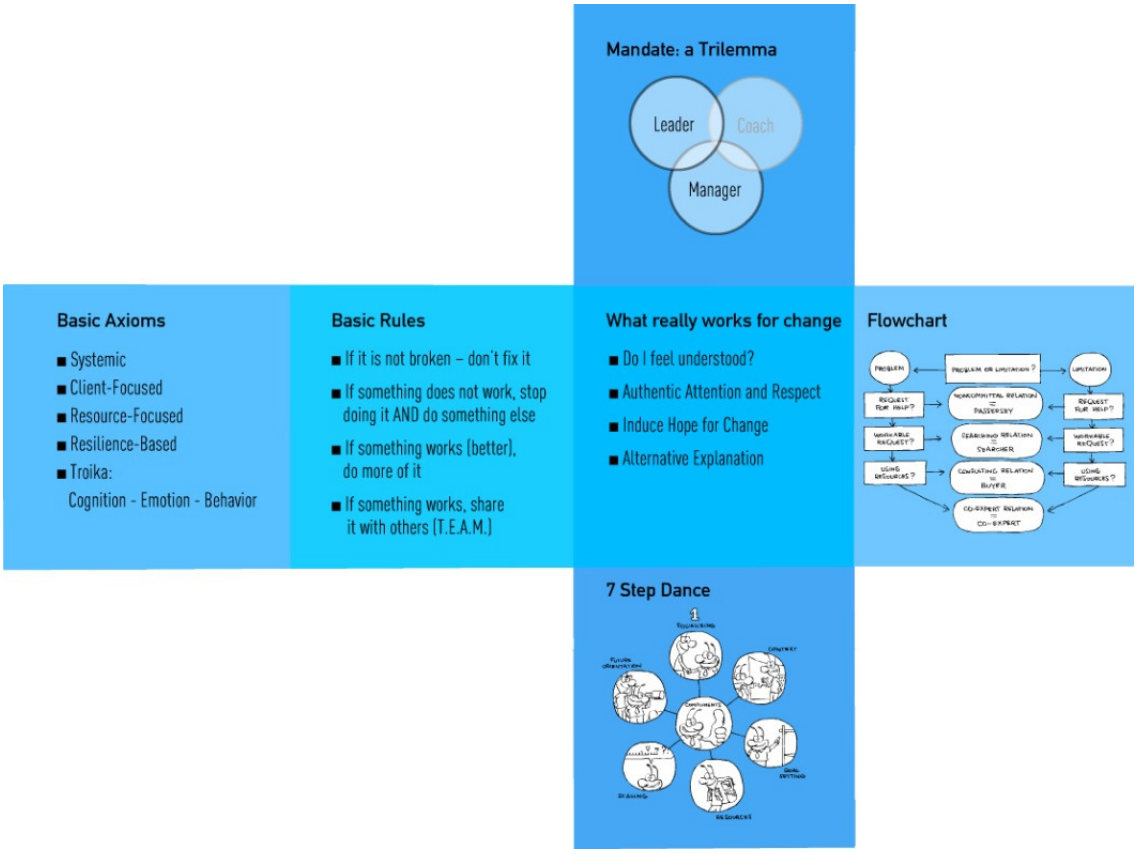


Figure 2. The SolutionCube Mindmeld commissioned by Louis Cauffman

Appendix C

Table 12

Techniques Involving Solution focused Thinking

Technique	Description	Example of application
Empowerment	Making reference to the self-efficacy of the client or putting him/her into a position of autonomy in regards to aspects of his/her own life.	"You said you wanted me to make an appointment with the banker, I'm confident that you can do that yourself."
Challenge/Stimulate/ Motivate	Stimulating or motivating the client to use his/her resources. Challenging the client to take matters in own hands.	The client wants to find out more about attending after-work schooling. The caregiver provides him with the necessary contacts and says that he is confident in the abilities of the client.
Adjust to the Level of Client	Modifying the approach of interaction when the client shows that he/she is not able to follow or to comply.	The client cannot follow the explanations. The caregiver then continues by sketching the explanation on paper.
Relieve/Not Overburden Client	Supporting client practically or mentally if it is clear that client is overstrained.	The caregiver asks client to come up with a solution to a problem. The client becomes confused and irritated. The caregiver proposes to think together.
Refraining from Steering the Client	Taking a passive stance, allowing the client to act in line with own convictions.	The caregiver only asks what the client thinks would be best, without superimposing his own views.

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Table 12 (*Continued*)

Technique	Description	Example of application
Modeling	Demonstrating a behavior to the client, so he/she can see how to do it and what results from it.	The caregiver helps the client to hang a picture and in doing so, shows him how to do it himself in the future.
Offer Choice	Offering the client a limited number of alternatives from which to choose from.	"You can either go with us to the theatre or stay here and watch TV."
Postpone Question	Putting an initial request for help on hold in favor of another, more urgent question.	"You told me about you thinking about getting back together with your ex-boyfriend, you said he hit you the last time you had a fight?"
Check Back with the Client	Checking with the client if a chosen approach is in agreement with him.	"Is the solution we talked about ok for you? Do you have any further questions?"
Helping Remember	Reminding the client of an agreement or ways of resolving an earlier problem.	"What did we do when you called me the last time when you misplaced your keys?"
Looking Back	Reminding the client of how things were in the past.	"Do you remember when you first started working there?"
Support Emotionally	Showing the client that one knows how he/she feels, that he/she is not alone.	"I can imagine that this must be hard for you."
Show Understanding/ Compassion	Showing compassion for the situation of the client.	"I know what you mean and I would feel the same."

Note. Examples of application are fictitious, but close in similarity to analyzed fragments.

Table 13

Directive Techniques

Technique	Description	Example of application
Propose Solutions/Give Tips	Bringing forward a proposal on how to solve the situation.	The client cannot think of a solution. The caregiver proposes one himself.
Steering the Client	Influencing the client to exert certain behavior or to comply.	"The best choice would be to go to the meeting."
Give Opinion	Communicating to the client what one's viewpoint is on a certain matter.	"I think you should not worry so much. In my opinion you are doing fine and made great progress."
Confronting	Address the behavior of a client which is inappropriate, prohibited or disruptive.	"You were out last night past the curfew again. That's not acceptable."
Prohibit/Give no Room	Forbidding the client to engage in certain behavior and/or omitting the client in voicing own concerns or wishes.	"I don't care if you don't like it, you'll go to the appointment."
Taking Over	Taking over the control of an interaction.	The client seem to have trouble to make progress, so the caregiver takes over the conversation.
Referring to Rules	Reminding the client of rules and arrangements that have to be abided.	"You have to make an appointment first before coming in."
Clarify Context for Client	Clarify the context for the client, which is seen as part of the problematic matter.	"She was not making fun of you, she was laughing at the movie."

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Table 13 (*Continued*)

Technique	Description	Example of application
Convincing	Explaining a viewpoint to the client in hopes that he/she will agree with that point of view and comply.	"It's very important that you take your medicine at the right time, otherwise they won't work."
Support Practically	Directly assisting the client in practical activities.	The caregiver helps a client fix his/her bicycle
Provide Solutions	Suggesting a solution to the client's problem.	"You could try going about it this way."

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Table 14

Miscellaneous/Neutral Techniques

Techniques	Description	Example of application
Interpreting Non-Verbal Cues	Deducing the emotional or mental condition of a client from posture, mimic, gestures and general behavior.	Because the client seemed tense and very upset, the caregiver first tried to calm him down and listen to him carefully.
Clarify	Making something clear that seemed ambiguous for the client by explaining and illustrating.	Explaining to the client that if he does not keep receipts, he will not get reimbursed should a bought item break within the warranty period.
Make Comparisons	Comparing what the client said or what the caregiver tried to convey to something analogous in order to clarify.	"Your favorite sports team changes its roster occasionally as well; it's the same with colleagues at work."

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Table 14 (*Continued*)

Techniques	Description	Example of application
Mirroring	Reflecting the behavior of the client, by picking up topics of conversation and mimicking facial impressions and general behavior of the client.	The client smiles and brings up his favorite sport team. The caregiver smiles back and asks about the team's latest performance.
Make Agreements	Coming to an agreement with the client on what to do.	"So, do we have a deal? You try it on your own and if you need help you can call me?"
Visualize	Illustrate an issue for the client by utilizing non-verbal means.	The caregiver gives client directions by making a sketch.

Note. Examples of application are fictitious, but close in similarity to analyzed fragments

Appendix D

1.1 "Een cliënt vertelde een onsamenhangend verhaal. Daarop heb ik het gesprek gestructureerd door samenvatten en herhalen. Hier werd hij rustiger van. Ik heb een aantal oplossingen aangedragen en gevraagd wat hij daarvan vond. OGW is dat je een cliënt zelf laat denken. In mijn opinie was hij daar op dat moment niet toe in staat en vond hij rust door het overnemen van het 'denken' door mij."

"A client was talking incoherently. Therefore, I structured the conversation by summarizing and repeating. This calmed him down a bit. I proposed a couple solutions and asked for his opinion. SFS is letting the client think. In my opinion, he was not able to do that in this condition; by me taking over the conversation, he was able to calm down a little."

1.2 "We krijgen een reorganisatie binnen ons cluster. Nu moesten cliënten en ouders/verwanten ingelicht worden. Ik heb een cliënt moeten inlichten, Ik wat ze er van vond, ze was erg onredelijk en kon ook niet tot bedaren komen. Ik heb daarom gepraat en verteld waarom en haar gerust gesteld, Ik ben niet bezig gegaan met OGW omdat naar mijn mening niet mogelijk was."

"Our location is being reorganized. Now, clients and their parents/relatives have to be informed. I had to inform a client, I asked what she thought about the change, she was frantic and could not be put at ease. Therefore, I talked and explained her why the change is taking place and I calmed her down, I did not apply solution focused practice, because in my opinion that was not possible."

1.3 "Cliënt is geheel onrustig vanwege onduidelijkheid. Haar geprobeerd duidelijkheid te geven, eerst mondeling, daarna alles uitgetekend op papier. Vanwege haar onrust was ze niet in staat om zelf mee te denken aan oplossingen."

"A client was confused and therefore very anxious. Tried to make things clear for her, first verbally, then on paper. Because of her discomposure, she was not able to participate in thinking about solutions."

1.4 "Een nieuwe cliënt heb ik heel streng benaderd. Hij kreeg geen ruimte zijn wensen aan te geven, zo is het en als je dit niet wilt, kun je hier niet wonen. Voor deze benadering is gekozen op basis van zijn vorige hulpverlening. Ik ken hem nog niet goed genoeg om zijn hulpvraag te kennen en door deze manier van benaderen, krijgt hij eerst ook niet de kans zijn wensen aan te geven over belangrijke zaken. Het is een dominante man, ik ga daarover heen door directief te zijn en hem geen ruimte te geven. Dit alles sluit totaal niet bij OGW aan. Echter, uit eerdere rapportage blijkt dat hij behoefte heeft aan structuur en vastigheid. Dus het zou wel kunnen dat blijkt dat dit zijn hulpvraag is. Dit moet echter nog blijken."

"I approached a new client very sternly. He got no room to express his wishes, that's how it is and if you don't like it, you can't live here. I chose for this approach based on the care he previously has received. I don't know the client well enough to know his request for help and through the approach I chose, the client doesn't get the chance to express his wishes in regards to important things. It is a dominant man; I overrode that by being directive and by not giving him room. All this isn't in line with SFS, at all. However, from previous reports I gathered that he seems to have a need for structure and certainty. Therefore, it could be that this is his request for help. This has yet to be seen."

1.5 "Momenteel begeleid ik een cliënt, die op dit moment voldoende heeft aan de veiligheid dat hij twee keer per week begeleiding krijgt. Er wordt weinig tot niets nieuws besproken. Hij woont thuis bij zijn moeder en de plannen voor intramuraal wonen zijn rond qua doelen. Als ik de cliënt vraag waar hij over wil praten, komt of doorvraag over bepaalde onderwerpen en hem bevraagt naar zijn oplossing, komt daar niet veel bijzonders uit. Hij lijkt niet in staat voor zichzelf te kunnen redeneren wat een oplossing zou kunnen zijn of dat kost hem zo veel moeite, dat hij er niet eens aan begint. Ook al pas ik OGW toe, het blijkt in dit geval beter over voetbal te praten en een kop thee te drinken, dan daadwerkelijk hulp te verlenen. Cliënt wil alles houden zoals het is. En wat niet gaat, gaat ook wel weer over. Prima natuurlijk, maar ik merk dat er geen uitdaging in zit voor mij. Nu ben ik hard aan het werk om de motivatie te vinden deze cliënt te blijven begeleiden. En op zo'n punt zit ik zelden. Terwijl ik dit schrijf, denk ik dat ik het maar eens bespreekbaar moet maken met mijn leidinggevende. Dus OGW kan ook voor jezelf werken. Vind mijn eigen oplossing."

"I attend to a client who is content with the certainty that he is attended to two times a week. Little to nothing new is talked about. He lives at his mother's and plans for intramural living

are made. When I ask the client what he wants to talk about, when I probe questions or ask about solutions to certain topics, there is not much of a response. He does not seem to be able to come up with solutions himself that the client does not seem to be able to come up with possible solutions himself and that this is so exhausting for him that he never tries. Even when I try to apply SFS it seems to be better to talk about soccer and drink tea, instead of trying to actually help him. Client wants to leave everything as it is. Things that are bad, will become better. This is great of course, but I realize that this is no challenge for me. I work hard to come up with the motivation to keep attending to this client. And that is rarely the case. As I write this, I think I have to talk about this with my supervisor. So, solution focused practice can also work for yourself. Find your own solution."

1.6 "Cliënten moeten als ze bij ons in het kantoor komen aan kloppen en wachten totdat wij de deur openen. Een cliënt klopt aan, maar ik ben in gesprek. Dus doe niet direct de deur open deze cliënt komt binnen en ik spreek haar hier wat geïrriteerd op aan. Maar zij had een ongelukje gehad op toilet dus haar broek was nat. Ik heb haar gezegd voor dat ik naar haar heb geluisterd dat ze moest wachten, maar dit was eigenlijk best wel urgent want haar hele broek was nat. Ik had even moeten vragen wat er zo dringend was dat ze aan de deur stond voordat ik direct ging oordelen."

"Clients have to knock and wait when they come in an office. A client knocks, but I'm having an appointment. Therefore, I don't open the door right away, the client enters and I confront her somewhat irritated. But she had a mishap at the bathroom and her trousers were wet. I told her that she had to wait before I listened to her. But his was actually very urgent because her entire pair of trousers was wet. I should have asked her what was so urgent that it could not wait before judging her preemptively."