Solution-Focused Therapy with Depressed Deaf Persons

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ABSTRACT. In this study, we present encouraging preliminary results on the application of solution-focused brief therapy (SFBT) to a special population. In a multiple case design, solution-focused therapy was used to treat three profoundly prelocutive deaf persons suffering from depression. The level of depression was assessed using a carefully validated adaptation of the Beck Depression Inventory-II (BDI-II); the treatment was manualized, and treatment integrity was assessed throughout all the therapy sessions. In all three cases, the BDI scores improved significantly; clients moved out of the clinical range. Therapy was brief, ranging from four to eight sessions over a maximum of 4.5 months. Limitations of the study and future implications are also discussed. doi:10.1300/J085v18n03_04

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Over the last 20 years, a number of outcome studies have documented the effectiveness of solution-focused brief therapy (SFBT) in a variety

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of clinical and non-clinical settings. Although earlier studies consisted of uncontrolled follow-ups of heterogeneous samples (Burr, 1993; de Shazer, 1985, 1991; George, Iveson & Ratner, 1990; Macdonald, 1994), much of the later research used stringent designs and standardized instruments on well-defined, homogeneous samples (Cockburn, Thomas, & Cockburn, 1997; Lindforss & Magnusson, 1997; Knekt & Linfors, 2004). Numerous single case studies have also been published in the last several years. (Conoley, Graham, Neu, Craig, O'Pry, Cardin, Brossart, & Parker, 2003; Franklin, Biever, Moore, Clemons, & Scamardo, 2001). The results from these studies suggest that SFBT is indeed an effective therapy approach worthy of direct comparisons with empirically supported treatments (Gingerich & Eisengart, 2000).

Thus far, four research projects have analyzed the use of SFBT with depressed patients using the BDI in their assessments. The first to utilize a randomized experimental design was the Sundstrom (1993) study, which compared a single session of SFBT with a single session of Interpersonal Psychotherapy for Depression in the treatment of 40 depressed female college students. No significant differences between the two treatments were found. This demonstrated that single-session SFBT was effective in reducing depressed mood.

In 2001, Lee, Greene, Mentzer, Pinnell, and Niles (2001) used SFBT with a small sample of 10 clients. Nine of the subjects showed clinically significant improvement. In Germany, Frederic Linssen (2003) compared SFBT with cognitive-behavioral therapy in a controlled, randomized study of outpatient clients. In this case, the results were not as positive, since SFBT tended to perform slightly worse than the alternative treatment (Linssen, 2003). The most recent study, conducted in Finland (Knekt & Lindfors, 2004), showed similar positive results for brief psychodynamic and solution-focused brief therapy, with SFBT clients improving earlier in therapy than clients in brief psychodynamic therapy. Altogether, these four studies imply that SFBT can be a useful therapeutic option for depressed persons, and moreover, it produces positive results in a relatively short period of time.

The aim of this paper is to explore the use of SFBT with a specific population of depressed, profoundly prelocutive deaf persons.[1] The deaf population is at higher risk than the hearing population in developing depression. Studies show that there are more cases of mild and moderate-to-severe depression in deaf adolescents, college students, and adults in comparison to their hearing peers (Leigh, Robins, Welkowitz, & Bond, 1989; Leigh & Anthony-Tolbert, 2001; Marcus, 1991; McGhee, 1995; Watt & Davis, 1991). It is usually assumed that the higher

risk for depression is associated with the additional difficulties and challenges that deaf people encounter in our society. Indeed, deaf people are usually described as a "cultural minority" with their own language (sign language is not just "signed English" or "signed Spanish," but a language in itself) and values.[2] This minority status in western societies makes it difficult for deaf people to receive adequate mental health services. Besides a linguistic barrier, deaf people with mental health problems are usually a geographically widespread minority. This makes it more difficult for deaf people to find psychosocial services (Gerber, 1983; Kitson & Thacker, 2000; Scheetz, 2004). Moreover, there are few therapists available who can communicate effectively in sign language with their clients, both in the U.S. (Leigh, Corbett, Gutman, & Morere, 1996; Pollard, 1996; Sussman & Brauer, 1999) and in Europe (European Society for Mental Health and Deafness, 2006). Therefore, there is a great need for cost-effective therapy approaches for this population; ones that could eventually be taught to sign-language-using therapists and interpreters.

We believed that SFBT could be a beneficial therapeutic option for depressed prelocutive deaf persons for several reasons. As mentioned previously, SFBT has shown promising results in the treatment of depression (Linssen, 2003; Knekt & Lindfors, 2004; Lee, Greene, Mentzer, Pinnell, & Niles, 2001; Sundstrom, 1993). It is a brief treatment that is simple and teachable. Also, solution-focused therapists are especially suited to working in a culturally sensitive way, as their cooperative, one-down approach promotes the development of a respectful therapeutic relationship. Essentially, it approaches what is usually described as "culturally affirmative psychotherapy" (Glickman & Harvey, 1996; Glickman & Gulati, 2003). Furthermore, the solution-focused emphasis on client resources and personal agency fits well with therapy for deaf persons since they live in an environment that usually pathologizes their experiences (Ouellette, 1998).

Therefore, we set out to test the effectiveness of SFBT with this population. To do so in a culturally sensitive manner, both the treatment and the instruments were adapted for profoundly prelocutive deaf people. The treatment was carried out with sign language interpreters, and the measuring instrument, a Spanish version of the Beck Depression Inventory-II (BDI-II) (Beck, Steer, & Brown, 1996) was adapted for profoundly prelocutive deaf people. This instrument was applied in a psychometric version with two formats. One was an adapted written form to be read by deaf persons, and the second was a videotape in Spanish sign language. Since deaf persons are usually not as open to

therapy and there is a lack of mental health services adapted for their needs, it is very difficult to recruit adequate samples. Therefore, we decided to use a multiple case-study design that would allow us to make meaningful inferences based on a few cases. This design was also coherent with the exploratory nature of our research project. Our hypothesis was that SFBT would produce a decrease in depressive symptoms, as measured by the BDI-II adapted for profoundly prelocutive deaf persons and with the "progress scaling question" (de Shazer, 1988, 1994).

METHOD

Sample

The sample was gathered at a non-for-profit association of deaf persons in Salamanca, Spain. In order to gain access to depressed deaf persons, the first author gave a series of seminars on depression. At the end of the seminars, he offered free treatment for those who wished to participate in the study. During the time of the research project, several people expressed interest in participating, but only three actually asked for therapy. We will briefly describe these three cases.

Case A ("Sebastian")

Sebastian is a 27-year-old, recently unemployed male. He comes from a hearing family. At the start of therapy he was divorcing his wife. He lived with a relative in Salamanca.

Case B ("Peter")

Peter is a 32-year-old, unemployed single male. He had recently moved back home with his parents. He is the only deaf person in his family.

Case C ("Sophia")

Sophia is a 48-year-old, married housewife. Her husband is also deaf, but his deafness is not profound. They have two hearing daughters, aged 17 and 22.

Therapist

The therapist for all three cases was Roberto Freire Hernando, a psychologist who had received a 2-year training in SFBT at the postgraduate

program in brief family therapy that the second author directs (*Master en Terapia Sistémica*, Universidad Pontificia de Salamanca). After agreeing to take part in the study, the therapist received from the first author education on deaf culture and on therapy using sign language interpreters. He was also given a manual summarizing this information, as well as a solution-focused treatment manual.

Since the therapist did not know Spanish sign language, a professional Spanish sign language interpreter was always present during the sessions. Two different interpreters participated in the three cases. Both had no knowledge of SFBT or of psychotherapy in general. Interpreters were assigned to sessions based on their schedules.

Treatment

The treatment used was SFBT and followed the specifications of the European Brief Therapy Association (EBTA) treatment manual for SFBT (Beyebach, 2002). Therefore, the Miracle Question was asked in every first session, pre-treatment changes and exceptions were discussed, and the scaling question was asked in every session. Approximately 45-60 minutes into the session, the therapist took a break and designed some compliments and tasks. These were given to the clients after the break. The sessions focused on constructing solutions, so that most of the time was spent discussing improvements and further goals. Therapy took place in the private office of the therapist, but the treatment was free of charge for the clients.

Usually, 2 weeks elapsed between one session and the next. Case A participated in a total of four sessions over 2.5 months; Case B, in eight sessions during a 3.5-month period; and Case C had seven sessions distributed over 4.5 months. All three cases had a mutually agreed upon termination. The format of the sessions was individual for cases A and B. In case C, the first three sessions were individual. The remaining five sessions were conjoint, with the participation of the husband and the children of the client.

Instruments

Beck Depression Inventory-II Adapted for Deaf persons (BDI-IIAD)

The Spanish version of the BDI-II (Sanz, Navarro, & Vazquez, 2003) was adapted by the first author (B.E.) following a complex process to

ensure its psychometric quality (Estrada, Delgado, & Beyebach, 2006). As in the original BDI-II (Beck, Steer, & Brown, 1996) and in its Spanish version, the scores of the BDI-IIAD range from 0 to 63, with higher scores indicating more symptoms of depression. Scores under 13 indicate minimal depression; between 14 and 19, mild depression; from 20 to 28 moderate depression; and above 29, severe depression.

The BDI-IIAD has two formats, one in videotape (where an interpreter translates the instrument into Spanish sign language) and another in written format (version adapted in Spanish). The instructions and questions are given on the tape, while the client completes the written form.

Progress Scaling Question

The progress scale is a clinical tool of SFBT (de Shazer, 1988, 1994), but has also been used as an outcome measure (Beyebach, Rodríguez, Arribas de Miguel, Herrero de Vega, Hernández, & Rodríguez-Morejón, 2000; De Jong & Hopwood, 1996; Fischer, 2004). It has also demonstrated its validity in several studies (Fischer, 2004; Herrero de Vega & Beyebach, 2005). In this study, it was used for both clinical and measurement purposes. The progress scaling question was asked in every session. The progress scale was phrased as follows:

> On a scale from 1 to 10, where 1 stands for when the problem that brought you in was at its worst, and 10 means that it is completely solved, where would you say it is today?

In previous outcome studies in Salamanca, the average score on the progress scale for first sessions had been 4.2 (SB = 2), and the average score for the last sessions, 7.2 (SB = 1.8) (Beyebach et al., 2000).

Treatment Integrity Measures

Two instruments were used in this study to measure treatment integrity. They were developed by the second author (M.B.) for the purpose of conducting a controlled study on stuck cases in SFBT (Herrero de Vega & Beyebach, 2004).

The *Technique Checklist* (TI-TCH), assesses the techniques used by the therapist during sessions. The techniques are considered either solution-focused (SF) (miracle question, pre-treatment changes, scaling question . . .) or problem-focused (PF) (externalization, family restructuring, reversal of attempted ineffective solutions, psychoeducation . . .).

This checklist determines a "solution-focused total score" and a "problem-focused total score," ranging from 0 to 11 for the "interview" part of the session, and from 0 to 2 for the "final message." A session is considered solution-focused if the SF total score is 3 or more *and* the PF total score is not above 3. A final message is rated as solution-focused if the SF total score is 1 or 2, and the PF total is 0. In this way, treatment integrity is ensured not only by the inclusion of certain solution-focused techniques, but also by the *exclusion* of problem-focused practices. For instance, a session with a SF total score of 8 *but* a PF total score of 4 would not count as solution-focused.

The "Global Treatment Integrity Rating" (TI-GR) provides a global rating of the degree to which a session was solution-focused versus problem-focused. Attention is not paid to specific techniques, but to the overall flavor of the conversation. Solution-focused sessions receive a positive rating (1, 2, or 3). Problem-focused sessions receive a negative rating (–1 or –2).

Both instruments are usually used by independent observers to code videotaped therapy sessions. In a preliminary study, the inter-rater reliability of the TI-TCH was Cohens kappa = 0.76. For the TI-GR, it was Cohen's kappa = 0.86. As for the validity of the two instruments, they discriminated adequately between Solution-Focused sessions (conducted by Steve de Shazer) and Structural Family Therapy sessions (with Salvador Minuchin as the therapist).

Procedure

The first author, with the additional support of a sign language interpreter, administered the BDI-IIAD to clients prior to the first therapy session. The original intent was to use the BDI-IIAD several times before therapy started to establish a baseline for the study. However, this proved to be impossible, as two of the three cases demanded therapy urgently.

It was also decided that the BDI-IIAD would be administered again after the third session, after the sixth, and after the last session. Therefore, it was used three times for Case A, four times for Case B, and four times for Case C. All administrations of the BDI-IIAD were conducted by the first author with the support of an interpreter.

Once the BDI-IIAD was completed (this took around 35-40 minutes), the first session was conducted by the therapist with an interpreter. For the remaining sessions, an interpreter was also present. The BDI-IIAD

was later readministered by the first author with the assistance of an interpreter in the specified intervals. The Progress Scale was asked at the end of all sessions.

After each interview, the therapist completed the TI-TCH and the TI-GR. The first author reviewed the tapes of the sessions (cases A and B, as C did not give consent to the taping), and confirmed the TI-TCH and the TI-GR ratings of the therapist. The TI-TCH and TI-GR scores of the therapist were used for the analysis.

CASE DESCRIPTION AND RESULTS

Case A ("Sebastian")

When Sebastian came for therapy, he indicated that he had attempted suicide several days before. He stated he was depressed due to the difficult work situation he had been enduring over the last 5 years and his unhappy marriage.

After using a risk scaling question to make sure that there was no danger of further suicide attempts, the majority of the first session was spent discussing Sebastian's pre-treatment changes. There were plenty of these. He explained that he had definitively quit his job, because of the constant harrassment from his (non-hearing impaired) colleagues. He was also divorcing his wife, with whom he had been married for almost 10 years. He confided that he had never felt supported by her over all these years. He had now moved to Salamanca and was trying to build a new life for himself. He had discovered his homosexuality and started dating a man. He was also trying to make new friends. His goals for therapy were to keep on this new track and to overcome the negative feelings from his bad marriage and work experiences. In spite of the pressure from his parents to move back to their place, he wanted to live his own life in Salamanca. On the progress scale, he put himself at a "4." At the end of the session, the therapist complimented him for his courage to make these difficult decisions. He also encouraged him to keep on doing what was helping him and to keep on working on his own future.

In the second session, Sebastian saw himself at a "7" on the scale. He felt happier, had moved to a flat that he shared with two female flatmates, had made new friends, and was looking for a job. Although his parents still wanted him to move back to his hometown, he was feeling supported in his decision to continue in Salamanca. Again, the therapist

complimented Sebastian on his achievements and encouraged him to keep on doing what was helping him.

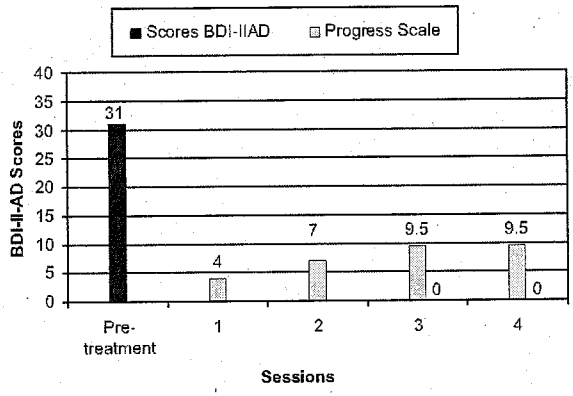
In the third session, Sebastian continued consolidating the positive changes he had made. These changes were also noticed by his family and friends. He had broken up with his partner, but they stayed "good friends." His answer to the scaling question was "9.5."

In the fourth and last session, Sebastian told the therapist that the changes had continued; his friendships with his new acquaintances had deepened, and he had developed new personal and professional choices. He said that he had reached all his goals for therapy. His answer to the scaling question was again "9.5." The therapist complimented him on his changes and once more encouraged him to keep on doing all the things that had helped him so far. Both agreed that no more sessions were necessary.

As displayed on Figure 1, Sebastian's scores on the scaling session increased once therapy started, and his BDI-IIAD values decreased. Before the first session, he had a BDI-IIAD score of 31, which corresponds to "severe depression." At termination, he was no longer clinically depressed and had a BDI-IIAD score of "0." Using the criteria for the Spanish population (Sanz, Perdigón, & Vazquez, 2003), this is a clinically significant improvement.

Sebastian's therapy was clearly solution-focused. On the Techniques Checklist, all sessions and all final messages had high solution-focused scores (ranging from 6 to 8 for the sessions and 1 to 2 for the final messages). No problem-focused techniques at all were detected. On the

FIGURE 1. BDI-II-AD and Progress Scale Scores for Case A (Sebastian)



Global Treatment Integrity Rating, all four sessions reached the maximum possible score of +3.

Case B ("Peter")

In the first session, Peter complained about the over-protectiveness of his parents. He wanted to be independent and find a job, but was very anxious and had many doubts about his capabilities. He also had many difficulties in his relationships with hearing persons. He explained that he wanted therapy to help calm down his anxiety, become more relaxed, and be in a better position to find a job. There were no evident pre-treatment changes. Also, Peter saw himself at a "3.5" on the progress scale. In the final message, the therapist complimented Peter for his resilience and his determination and asked him to keep track of anything that helped him to go up to a "4."

In the second session, Peter's rating on the progress scale had risen to a "5." He had developed a plan to get a position that interested him. He also explained that the first session had helped him to differentiate between his problems with his parents and his difficulties with other people. The therapist complimented him on being able to draw this distinction and suggested a task in relation to his hearing friends. In the next session, Peter was still feeling frustrated about his interactions with hearing people, but he also saw some changes. The session focused on this topic and at the end of the conversation Peter described himself at a "6" on the scale. He received compliments from the therapist, and the suggestion to keep on doing what he had found helpful.

In the fourth session, Peter informed the therapist that he had not gotten the job that had most interested him, but he had found another job. He had moved to a place of his own and was improving his relationship with his deaf and hearing friends. He saw things at a "5.5" on the scale. Again, the therapist complimented Peter on his improvements and told him to continue doing what was helpful for him.

In the fifth and sixth sessions new improvements were described. Peter explained that he was very happy with his new job and that his relationship with his parents had improved. As to his social relationships, he was strengthening ties with his deaf friends and spending less time with his hearing friends. In the fifth session, he saw his situation at a "6," and in the sixth, at a "6.5." In the sixth session, he mentioned his concerns about his excessive cigarette and alcohol use. The therapist provided some psychoeducational advice on this topic and after compli-

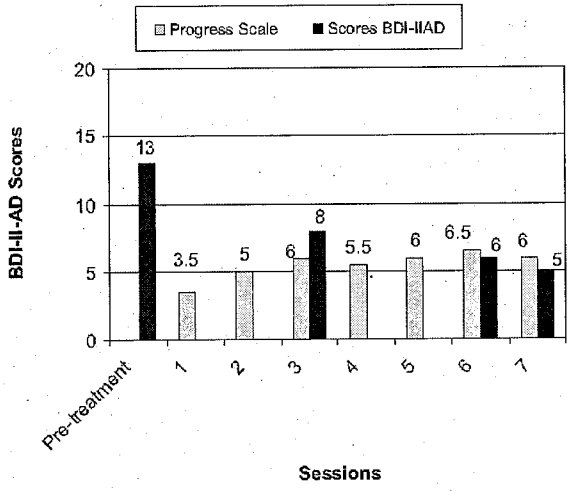
menting Peter for his determination to quit smoking, proposed the "toss a coin" task (Berg & Miller, 1992) to help him reduce smoking.

In the seventh session, Peter told the therapist that he had consolidated all of the changes he had desired to make. Furthermore, the "toss a coin" task had been useful and he had managed to not smoke for 8 days. He stated that he saw himself at a "6" on the scale. Interestingly he remarked that although a "7" would be great, he preferred to stay at a "6" for the time being. He decided to terminate therapy, and the therapist concluded their sessions by complimenting Peter again on the changes he made, his hard work, and encouraged him to continue with these changes.

As can be seen on Figure 2, there is a consistent trend upwards on the scaling question for Case B with Peter moving from "3.5" in the first session to "6" in the last. This improvement occurs in conjunction with a reduction in the BDI-IIAD scores, from 13 (the margin between "minimal depression" and "mild depression") in the first session, to a score of 5 after the last session.

All of Peter's therapy sessions can be described as solution-focused since they received a positive score on the Global Treatment Integrity Rating (range 1-3). On the Techniques Checklist, all sessions (range 5-9) and all final messages (range 1-2) had high Solution Focus scores. Some problem-focused techniques were also used (i.e., the psychoeducational

FIGURE 2. BDI-II-AD and Progress Scale Scores for Case B (Peter)



remarks by the therapist, especially about the smoking and alcohol issues), but the Problem Focus scores never reached the established threshold of 3.

Case C ("Sophia")

Sophia asked for an appointment with the therapist without indicating a specific reason for coming. She came alone for the first three sessions, then after the third session, her husband (who is also deaf) and their two daughters (both of them hearing, but with a good command of sign language) joined her for sessions.

In the first session, Sophia asked for help to reduce her anxiety and sadness and to improve her self-esteem. She complained a lot about her relationships with other non-hearing persons and with her daughters. When asked about pre-treatment changes, she said that she was feeling somewhat better, but had no clear descriptions of these improvements. She was also unable to answer the Miracle Question, in spite of the therapist's persistence. On the scale, she rated herself at a "2." The therapist ended the session by complimenting Sophia for not having given up and asking her to keep track of any further improvements that might take place.

During the second and third sessions it was also difficult to generate clear descriptions of exceptions or improvements. So the therapist stayed "behind his client," clarifying Sophia's goals for therapy and constructing a positive therapeutic relationship. This proved to be a challenging task, as Sophia had difficulty understanding some of the questions and showed distrust of the interpreters, constantly monitoring the accuracy of their translations. Even so, a good therapeutic alliance was built and her situation improved slowly, with her answers to the progress scaling question increasing to a "3" in the second session then to a "5" by the third session.

Since Sophia continued to complain about her relationship with her daughters, the therapist suggested that her daughters and husband could join her for the next sessions. The husband did in fact attend the rest of the sessions with his wife. One of the daughters came for the fifth session, and the other came for the fifth and sixth session.

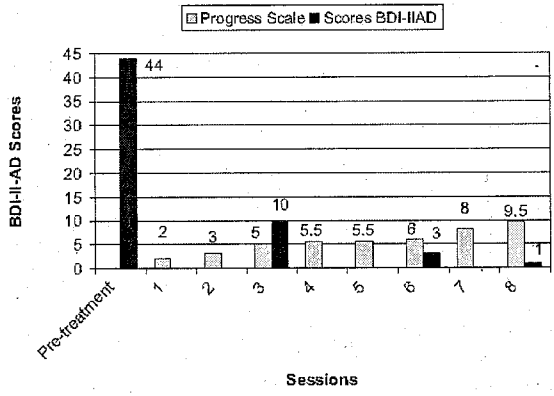
During the fourth, fifth, and sixth sessions, Sophia was able, with the help of her family, to describe more changes and to mobilize her resources in a creative way. She reduced her anxiety and stress and improved communication with both daughters. She and her husband also became more effective in dealing with difficulties at home. Sophia

started to depend more on her husband, instead of trying to manage everything on her own. On the progress scale, Sophia rated a "5.5" in the fourth and fifth sessions, a "6" in the sixth, and an "8" by the seventh session. During these sessions, the therapist continually complimented Sophia and her family on their progress and asked them to observe how they were producing these changes and to keep track of any new improvements. He also gave some psychoeducational advice to Sophia on how she could improve her social skills and strengthen her daily autonomy.

By the last session (the eighth) Sophia stated that she was no longer feeling anxious or stressed out. Instead, she felt happier and more capable of doing things on her own. She also felt that she was now physically looking better. She answered "9.5" to the scaling question. The therapist asked about possible relapses and Sophia responded that she now felt able to handle any new difficulties that might arise. Now she felt stronger and better able to tackle possible problems, but she also added that she could recognize earlier when to ask her husband for assistance. She expressed gratitude for the help she had received from the therapist, but also explained that now she felt able to keep on going on her own. Therefore, she agreed to terminate therapy. The therapist concluded their sessions by complimenting Sophia once more and crediting her for all the changes she had accomplished.

The scaling question scores and the BDI-IIAD scores of Sophia over the course of therapy are represented in Figure 3. There was a constant improvement on the scale, from a score of "2" in the first session to a

FIGURE 3. BDI-II-AD and Progress Scale Scores for Case C (Sophia)



score of "9.5" in the last. The BDI-IIAD score before the start of therapy was 44, indicating "severe depression." After the last session, it dropped outside the clinical range to a 1, which again indicates a clinically significant improvement (Sanz, Perdigón, & Vazquez, 2003).

Regarding treatment integrity, Sophia´s treatment can also be described as solution-focused. The Global Treatment Integrity Rating was always 2 or higher (range 2-3) and on the Techniques Checklist, all sessions (range 7-9) and all final messages (all final messages scored 2) had high Solution Focus scores, with Problem Focus scores of "1" on only three occasions.

DISCUSSION

We applied manualized and integrity-checked SFBT in three cases of profoundly prelocutive deaf depressed persons, using an adaptation of the Beck Depression Inventory-II, the BDI-IIAD. In all three cases, there was a clear, clinically significant reduction of BDI-IIAD scores from pre-treatment to termination. In all three cases, this reduction took place progressively, with the BDI-IIAD scores decreasing with subsequent administrations. This change corresponded with a steady rise in the answers to the progress scaling question asked at the end of each session.

Before we enter into a more detailed discussion of these results, we would like to acknowledge the limitations of the research design we used. Multiple case studies are an appropriate methodological choice when the peculiarities of a population make it difficult to obtain a large sample size (Dukes, 1965). However, such studies are difficult to generalize. An additional limitation to our research is that no proper baseline was established before the treatment was introduced. This would have increased internal validity, ensuring that the effects (i.e., the reduction in BDI-IIAD scores) were really due to the treatment application. In our case, it was not possible for us to obtain baseline values. Deaf persons tend to be more distrustful of mental health professionals and less likely than hearing persons to ask for psychological help, and only a small percentage of deaf people with severe mental health problems actually receive treatment (Vernon, 1983). Thus, postponing therapy until baseline BDI-IIAD measures could be obtained would have likely led to pre-treatment dropout. In addition, two of the three subjects in this study requested therapy urgently. One of the clients even had a recent suicide

attempt. This made it inappropriate to postpone the start of therapy until baseline measures could be determined.

Another threat to internal validity was the participation of interpreters in the sessions. This added to the external validity of our study (since most therapy with deaf persons is conducted with interpreters), but creates some doubts as to the possible effects of the interpreters.

We would also like to acknowledge that the treatment integrity ratings were not made by blind judges, but by the therapist himself. However, the supervision of the integrity ratings by the first author increases confidence that in all the three cases therapy was solution-focused and conducted in a competent and culturally respectful way.

Despite these limitations, we feel that our research provides encouraging preliminary evidence on the potential benefits of SFBT for depressed deaf persons. In all three cases there was a dramatic clinically significant decrease in the BDI-IIAD scores, with a corresponding increase in the scaling question ratings. This suggests that the treatment was quite successful in all three cases, despite the difficulties involved in working with interpreters, especially in the establishment of a positive therapeutic alliance. It should also be emphasized that the treatments were brief, ranging from only 4-8 sessions, and from 2.5 to 4.5 months.

There are a number of questions that future research may address. First of all, it would be valuable to determine if the positive results obtained at termination are maintained at follow-up, since the psychotherapy literature on depression indicates that there is a high percentage of relapse (Roth & Fonagy, 1996; Hollon & Beck, 2004). It would also be interesting to replicate this research by performing more single-case studies of SFBT with this particular population. If our promising results are replicated, it may then be appropriate to undertake controlled, randomized trials.

We also think that it would be especially valuable to replicate this study with therapists fluent in sign language and even with deaf therapists. As SFBT is a relatively simple, teachable method, this should not be an impossible enterprise. This would improve therapeutic communication, especially in conjoint sessions. It would also be easier to apply SFBT to the treatment of deaf persons with other types of mental health problems besides depression.

Another challenge is to adapt SFBT more fully for use with prelocutive deaf persons. The therapist in our study reported that all three clients had some difficulties with the Miracle Question and in general, struggled to answer future-oriented questions. In contrast, scaling questions were easily understood, and provided more specific and practical

information. Although we can only speculate about the reasons for these difficulties, we do not believe it is a translation issue, rather it may be related to the way in which deaf persons process future-oriented information. Apparently, it was difficult for our clients to imagine themselves in a hypothetical problem-free situation. We intend to perform additional process research on the taped sessions from this study to develop more refined hypotheses on which elements of SFBT are more and less useful for deaf persons. Hopefully, this will help us to develop an even more effective solution-focused treatment for this population.

NOTES

1. Prelocutive deaf persons are persons that are deaf from birth or become deaf before they reach the age of three, and therefore, have never acquired oral language.

2. In this study, as is usually done in the literature on deafness, we will write "deaf" to refer to people that do not hear, use sign language to communicate, and identify themselves with other deaf people as part of a deaf community.

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