Journal of Systemic Therapies, Vol. 33, No. 2, 2014, pp. 35–49

# A SOLUTION-FOCUSED THERAPY GROUP DESIGNED FOR CAREGIVERS OF STROKE SURVIVORS

RHEA PLOSKER
Inspiration Solutions, Inc., Toronto, Ontario
JEFF CHANG
Athabasca University and The Family Psychology Centre, Calgary, Canada

*In 2006, 44 million Americans acted as informal caregivers for other adults. In Canada, in 2007, this number was 2.75 million. Stroke is the leading cause of disability in North America, so there is strong economic and social value in supporting stroke caregivers. Moving Forward, a group for stroke caregivers, builds on a Solution-Focused Therapy foundation. The group uses a modular, flexible structure easily learned, used, and modified for application to different settings. Positive feedback resulted in the group now offered as an ongoing service. The greatest challenge is recruitment. Many interested caregivers have too many demands on their time to commit to regular attendance. Work is underway to explore formats best suited to caregiver availability constraints.*

The Moving Forward group for caregivers of stroke survivors was born from the commitment of social workers at a Toronto rehabilitation hospital. Stroke rehabilitation focuses on the patient, but those working in the field know that family caregivers play a critical role in success. The first 3–6 months post-stroke are the most difficult as caregivers navigate many life changes (King, Ainsworth, Ronen, & Hartke, 2010; Parag et al., 2008). This same period is also crucial for the stroke survivor's rehabilitation, with survivors doing better if their caregivers are well supported (Parag et al., 2008). In developing the group, our goal was to create a meaningful intervention for caregivers who have to reorganize their lives post-stroke as well as to make it easy for facilitators to learn, use, and adapt to a variety of caregivers and settings.

The authors thank the social work team at Providence Healthcare for supporting the Athabasca University student practicum and project leading to the development of the Moving Forward group.

Address correspondence to Rhea Plosker, M.A.Sc., M.C., CCC, 71 Saint Clements Ave., Toronto, ON M4R 1H1, Canada. E-mail: rplosker@inspirationsolutions.com



G4328.indd 35 8/12/2014 12:54:10 PM

In this paper, we review the literature supporting the development and use of a Solution-Focused Therapy (SFT) approach to a group for stroke caregivers. We describe the Moving Forward group process and modular format, and the tools and exercises used to bring the group to life. We conclude with a summary of outcomes to date and opportunities for future work.

## REVIEW OF THE EXISTING LITERATURE

In the United States, as of 2006, 44 million adults were acting as caregivers for other adults (Lutz & Young, 2010). In Canada, as of 2007, 2.75 million people were acting in a similar role (Canadian Institute for Health Information [CIHI], 2010). The work of caregivers is valued at $306 billion dollars/year in the United States and $25 billion/year in Canada (CIHI, 2010; Lutz & Young, 2010). Over half of caregivers are managing very well, but the rest experience difficulty coping, with 4% experiencing significant coping challenges (Kranswick & Dosman, 2008). Caregivers experience higher rates of depression and anxiety than the general population (Gaugler, 2010; Lutz & Young, 2010). Many caregivers also experience stress-induced physical symptoms, including disturbed sleep, decreased immune response, and even increased mortality (Legg et al., 2011).

Stroke is the leading cause of disability in the United States and Canada, making stroke caregivers a significant cohort worthy of attention (Heart and Stroke Foundation, n.d.; Lutz & Young, 2010). To understand the experiences of stroke caregivers, it is important to learn something about the nature of stroke. The Heart and Stroke Foundation (n.d.) describes stroke as the sudden loss of brain function due to a loss of blood flow to the brain or bleeding in the brain. Every year, 795,000 Americans and 50,000 Canadians have a stroke. Older people experience the majority of strokes, with rates doubling every ten years past age 55. Regardless of cause, the effect of stroke varies widely based on the affected area of the brain. Over 75% of stroke survivors live with some form of disability, and 50% live with a significant disability that seriously limits one or more functional capacities, such as self-care, mobility, communications, or cognition.

The abruptness of stroke leaves no time to plan or adapt, creating a caregiving journey that starts differently than when caregivers have time to gradually adjust to the increasing needs of their loved ones (Gaugler, 2010; Ontario Stroke Network, 2010). Stroke recovery is often variable and unpredictable, with the uncertainty creating additional challenges for both survivors and caregivers (Silva-Smith, 2007). Stroke caregivers experience a steep learning curve about how to best support the recovery of their loved one, while simultaneously reconstructing their own lives to include a new caregiving role (Gaugler, 2010; Ontario Stroke Network, 2010).

## THEORETICAL FOUNDATIONS

The challenges facing stroke caregivers are well understood. Unfortunately, there are few quantitative or qualitative studies assessing interventions supporting this cohort (Brereton, Carroll, & Barnston, 2007; Eldred & Sykes, 2008; Franzen-Dahlin, Larson, Murray, Wredling, & Billing, 2008; Lee, Soeken, & Picot, 2007). Legg and colleagues (2011) published the most recent review of stroke caregiver interventions, reviewing only completed randomized controlled trials. Seven studies involving 1,007 participants met the selection criteria. The small number of published studies indicates positive outcomes from education, support, and counselling interventions. While we do know that interventions help, the wide variations in study designs, interventions, and outcome measures prevent firm conclusions about which interventions are most useful and in which context.

Most studies incorporating a specific theoretical foundation use the transactional model of stress and coping (Lazarus & Folkman, 1984) to explain caregiver experiences and conceptualize intervention (Eldred & Sykes, 2008; Gaugler, 2010; Glasdam, Timm, & Vittrup, 2010). Lazarus and Folkman (1984) conceptualized coping as a balance between one's appraisal of demands and available resources. Individuals have trouble coping if the appraised demands are greater than their available resources. This definition reflects that people are subject to different combinations of demands and stressors, perceive them in different ways, and have different coping resources at their disposal (King et al., 2010). Interventions for stroke caregivers help people adjust to their "new normal" primarily by enhancing their resources, but also by eliminating stressors or changing the appraisal of stressors where it is feasible to do so (Legg et al., 2011).

While there is little research on stroke caregiving, the New York University Caregiver intervention supporting Alzheimer caregivers provides strong support for a well-designed set of interventions, ideally provided over an extended time (Mittelman, Roth, Clay, & Haley, 2007). This 19-year longitudinal study evaluated a multifaceted intervention including individual, family, and group counselling, as well as ongoing telephone support. Outcome measures included measures of health, depressive symptoms, social support, stress appraisals, and nursing home placements of the Alzheimer patient receiving care. There were significant improvements on all measures from the intervention, compared to the control group.

## SOLUTION-FOCUSED THERAPY WITH CAREGIVERS OF STROKE SURVIVORS

Solution-Focused Therapy (SFT) is a brief therapy focusing on goal setting and maximizing personal resources (de Shazer et al., 2007). It encourages hope by examining "what's working," contrasting with the focus on deficits found in the

medical model (Kondrat & Teater, 2010). The future focus supports caregivers to plan their post-stroke lives, and the emphasis on maximizing resources integrates well with the transactional model of stress. A brief therapy, SFT also aligns with the current environment of limited funding for caregiver services.

SFT emphasizes the importance of language. While acknowledging and validating a client's problem, SFT primarily focuses on asking questions to elicit exceptions to the problem, or times when the problem is less severe (Froerer, Smock, & Seedall, 2009; Grant, 2012). The SFT process of constructing exceptions to the problem, rather than the problem itself, generates hope by drawing clients' attention toward their already proven ability to master challenges—*what works* (Kondrat & Teater, 2010; McKeel, 2011; Postma & Rao, 2006). This naturally leads to conversations about constructing future solutions (de Shazer et al., 2007; Kondrat & Teater, 2010).

There are no recent published studies evaluating SFT applied to work with stroke survivors and their caregivers. However, there is support for the use of SFT applied to health care and to working with ill adults. Simon (2010) noted the importance of a hope-oriented therapy in the health care sector, where it is easy for complex clinical problems to overwhelm patients and families. Quick and Gizzo (2007) discussed the benefits from using SFT with patients of the Kaiser Health Maintenance Organization in California. Several recently published papers describe applications of SFT to Emergency Room suicide assessment, patients with HIV/AIDSs, and Chrohn's disease (Froerer et al., 2009; Kondrat & Teater, 2010; Vogelaar et al., 2011), suggesting SFT reduces hopelessness and increases quality of life and ability to cope.

SFT is also a good fit for group work. Gingerich, Kim, Stams, and Macdonald (2011), reviewing SFT outcome research, found SFT group interventions had a medium outcome effect size, compared to the small effect size found in individual interventions.

## SFT PRACTICES APPLIED TO THE MOVING FORWARD GROUP

The Moving Forward group uses a consistent solution-focused process flow throughout all sessions, a common practice in solution-focused groups (Froerer et al., 2009; McCollum, Trepper, & Smock, 2003; Quick & Gizzo, 2007; Sharry, 2008; Smock et al., 2008). The Moving Forward process flow uses three key solution-focused practices:

1. *Setting goals*. Setting goals facilitates solution building. Movement toward goals can be described even when goal attainment is not complete.
2. *Look for "what's working"* or times when the problem is less severe. Focusing on times when we cope better permits strengths, skills, and resources to become more visible and future possibilities to emerge.

3. *Take small steps toward change*. Small changes lead to bigger ones. If something works, keep doing it. If something does not work, try something else.

## Solution-Focused Techniques Used in the Moving Forward Group

Six solution-focused techniques are embedded in Moving Forward group sessions. In this section, we describe the techniques, before describing how we implement these techniques in the group.

*Pre-session Change.* The facilitator asks the client to describe positive changes that have already occurred prior to the first group session (de Shazer et al., 2007; Trepper et al., 2008). Looking for "what's already working" is a hopeful way of orienting caregivers to setting goals for the future (Sharry, 2008).

*Goal-Setting Questions and the Miracle Question.* We use goal-setting questions to draw forth a description of what will be different for a client when the problem is solved (McKeel, 2011). The facilitators frame goals using language that describes the presence of an acceptable solution, rather than the absence of a problem (Trepper et al., 2008). The Miracle Question is one type of goal-setting question intended to promote hope and prepare clients to notice exceptions (de Shazer et al., 2007; McKeel, 2011). Sharry (2008) provides the standard formula for the Miracle Question:

> Imagine when you go to sleep one night a miracle happens and the problems that brought you to therapy completely disappear. As you were asleep, you do not know that the miracle has happened. When you wake up, what would be the first signs for you that the miracle has happened? (p. 35)

Simon (2010) noted that when working with people who are managing illness, setting the appropriate context for the Miracle Question is critical and the standard formula might need modification. For example, a goal-setting question might focus on what will be different for attendees if the Moving Forward group proves helpful for them, or if they were their "best selves" within the present circumstances, rather than using the Miracle Question as originally articulated.

*Scaling Questions.* Scaling questions help clients describe where they see themselves in relation to their goal (Trepper et al., 2008). Clients describe their current state given that 10 means their goal is achieved and 0 or 1 means their problem is at its worst. Sharry (2008) emphasized the importance of scaling questions for highlighting progress already made, and the resources and skills that led to this progress. Scaling questions are useful for breaking goals into smaller, more easily achievable sub-goals. For example, the facilitator can ask the client how to move even a half point closer to their goal. It might also be useful to scale confidence that change will endure, or motivation, rather than scale the goal itself (Green, 2011).

Scaling for confidence or motivation may be more relevant indicators of change to the client than scaling for progress, especially when progress is "up and down."

*Highlighting Exceptions and Building Solutions.* Exceptions are times when the problem is less severe or not present. A facilitator might ask clients to describe a time when things have been even a little bit better, or when they were more confident that things would be better (Green, 2011). Scaling questions help to highlight exceptions. Sharry (2008) described how questions relating to behaviors, thoughts, and emotions at times of exceptions serve to amplify client strengths. Such conversations help the client build future solutions based on past success.

*Relationship Questions.* De Shazer and colleagues (2007) and Sharry (2008) noted the importance of relationship questions for helping clients gain new perspectives by seeing themselves through others' eyes, thereby understanding the interpersonal nature of solutions. Group engagement is one direct and effective way of incorporating relationships into conversation. When setting goals, asking scaling questions, or highlighting exceptions, facilitators might frame the question from the perspective of what family members, group attendees, friends, or even the family pet might notice.

*Compliments and a Task.* At the end of an SFT session, the facilitator traditionally takes a break, then returns and provides the client with a well thought-out compliment (de Shazer et al., 2007). Trepper and colleagues (2008) suggest that compliments are intended to encourage clients to continue to do what is working for them, and to try changes or experiments. Mid-session compliments are also common, although they are frequently indirect. For example, a mid-session compliment might entail expressing curiosity or interest in how the client managed to cope successfully with a difficult situation (de Shazer et al., 2007).

End-of-session compliments bridge to a final homework task incorporating the client's goals and readiness to change (Fiske & Zalter, 2005). Homework tasks come directly from the client or are suggested by the facilitator or other group members (Froerer et al., 2009). Homework may consist of tasks of observation, aimed at increasing the client's noticing of solutions (e.g., noticing when the client feels more confident or copes in a preferred way), or tasks of action (e.g., pretending the miracle has happened or the goal is met, or doing more of what the client has reported already works) (De Jong & Berg, 2013).

## MOVING FORWARD GROUP PROCESS

These six solution-focused techniques appear in the same order across all Moving Forward sessions, as described in Figure 1. Using a flexible, modular group format,

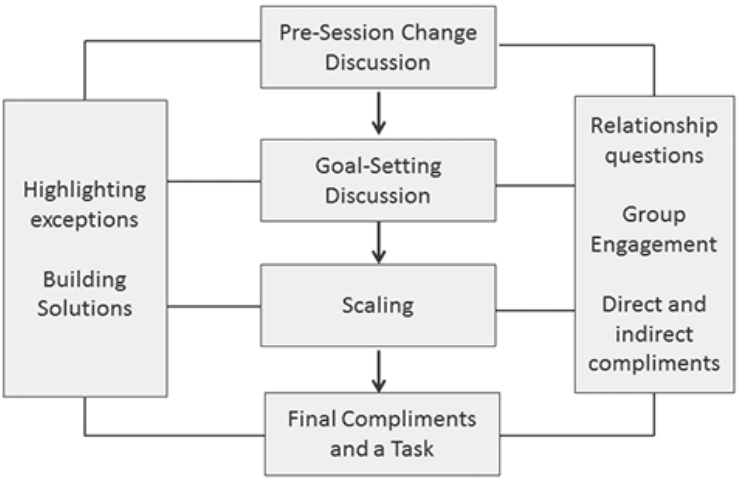


**FIGURE 1. Moving Forward Session Flow.**

the intent is to provide a consistent experience for caregivers, while making it easy for facilitators to learn the group process. While the same techniques and order are used, topics, questions, exercises, and time allocated vary based on attendee preference, number of sessions, and group size. Materials include a facilitator tutorial, session guides for both group attendees and facilitators, and a resource package supporting common information requests.

The facilitator tutorial provides training on the group process, the SFT techniques used, and how to tailor modules for different group formats and participant needs. With the exception of the first and last sessions, which include introductory and concluding material, the sessions follow a standard format and do not contain stroke-specific content. The tutorial describes several modifications. For example, the first session guide can be adapted for single-session group sessions, and the guide for middle sessions contains instructions for adapting the content an ongoing open group. The facilitator guides provide specific instructions, including recommended time allocated to each step in the group process and suggested exercises. The resource package contains information specific to stroke. The design permits facilitators to update information easily or replace resource materials according to the needs of different caregiver cohorts.

## Bringing the Moving Forward Group Process to Life

The Moving Forward session flow comes to life through tools and exercises used, changed, or modified according to group preference.

*Pre-session Change.* We recommend that facilitators use flip chart sheets to accomplish two important functions throughout the group, contributing to the solution-building process—amplifying pre-existing strengths and documenting pre-session and between-session progress.

At their first session, attendees describe their best qualities and the best qualities of the people for whom they are caring. Facilitators maintain this "best qualities" list, post it before each session, and add to it as part of providing compliments.

The second tool is the "what works" list, a list of coping strategies and resources caregivers have found helpful. Suggestions range from self-care recommendations, such as taking time to exercise or meet with friends, to time management tips, such as running errands while their loved one is napping or at physiotherapy. An initial "what works" list, summarized from prior groups, is included in each attendee guide. The facilitators also maintain a "what works" list from the current group, posting it at the start of each session and adding to it as new ideas arise. A graduation certificate provided in the final session summarizes the group-specific "what works" list.

The second and subsequent sessions start with asking what has been better or helpful since the last session (Sharry, 2008). This question typically results in multiple additions to the "what works" list. Group members see the growth of their collective strengths and solution-building activities graphically displayed over time.

*Goal-Setting.* After the initial discussion about pre-session or between-session change, a goal-setting question, based loosely on the Miracle Question, creates a future-oriented focus. In the first session, the lead facilitator asks group attendees to assume the group will be helpful to them in some small way, then to describe the first thing they will notice that will let them know it has been helpful. Facilitators amplify goals using relationship questions, such as asking what others will notice and what the group members might notice in each other. In second and subsequent sessions, goal-oriented questions arise from the discussion theme selected by group attendees.

One of the keys to creating group cohesion is to uncover common themes in goals (Sharry, 2008; Smock et al., 2008). This is particularly important for Moving Forward, since attendees may initially appear to have little in common other than their loved one's stroke. For example, participants have commonly identified themes of acceptance and challenges with self-care. Goal-setting questions, scaling questions, and relationship questions help identify common themes. Facilitators can then encourage the group to build solutions around these themes.

*Scaling.* After answering a goal-setting question, attendees scale their goals relative to their desired future state. Gingerich and colleagues (2011) noted that the most effective goal-setting questions integrate with seeking exceptions. Scaling questions help to highlight exceptions by emphasizing progress already made toward meeting the goal (Sharry, 2008). For example, an attendee with a goal of

improved self-care might be asked to rate his or her level of self-care today on a scale of 1 to 10. A "10" means he or she has reached the goals and a "1" represents the "worst self-care ever." Since things are almost always better than the worst ever, even a low number is likely to indicate some progress, which can be elaborated upon in further discussion. Even if the participant still does not find things "good enough," it is still useful to distinguish the small differences that make a difference to the participants.

In stroke recovery, progress is slow, bringing many ups and downs. Group members are encouraged to set micro-goals by describing how things will be different when they have moved forward by even a half point. If a caregiver is having a difficult day, facilitators often suggest scaling confidence in their ability to cope, or even to discuss what caregivers are doing to prevent things from getting worse (Sharry, 2008).

*Highlighting Exceptions and Building Solutions.* Solutions develop throughout the process of setting goals, scaling those goals, and then determining how to move forward even by one small step. Moving Forward supports solution building with a visual tool. This tool integrates a solution-focused coaching model designed by Palmer (2007) with a CBT-visual tool for action planning suggested by Sage and colleagues (2008), and is provided in Figure 2.

Each caregiver places their goal at the top of the staircase and their current scale on the appropriate step. Facilitators lead a discussion on what will be different upon meeting their goal, the options for climbing one small step at a time toward their goal, and what differences the caregiver and others will notice at each step. Facilitators suggest that each small step should be something achievable in the next week, with at least 80% confidence (Sage et al., 2008).

The path taken toward solution building, either through use of this tool,or through less formal solution-focused discussions, depends on group preferences. The important thing is to encourage group engagement in a way that amplifies caregiver strengths and resources (Smock et al., 2008).

*Final Compliments and a Task.* In Moving Forward, both facilitators and group members deliver compliments, and each group member selects their own task. Similar to Thorslund (2007), the Moving Forward group does not use a therapeutic break. Instead, group members discuss what was helpful for them and the best qualities they noticed in others. The secondary facilitator for each session then delivers both individual and group compliments. The secondary facilitator primarily observes, listens, and takes notes. We found it very effective to have a secondary facilitator in each session who speaks up at the end and comments on the strengths and "best qualities" witnessed in the session.

As is common with solution-focused coaching, caregivers are encouraged to select specific tasks from the solution-building discussion they are confident they can achieve in the next week (Green, 2011). Some group members might benefit

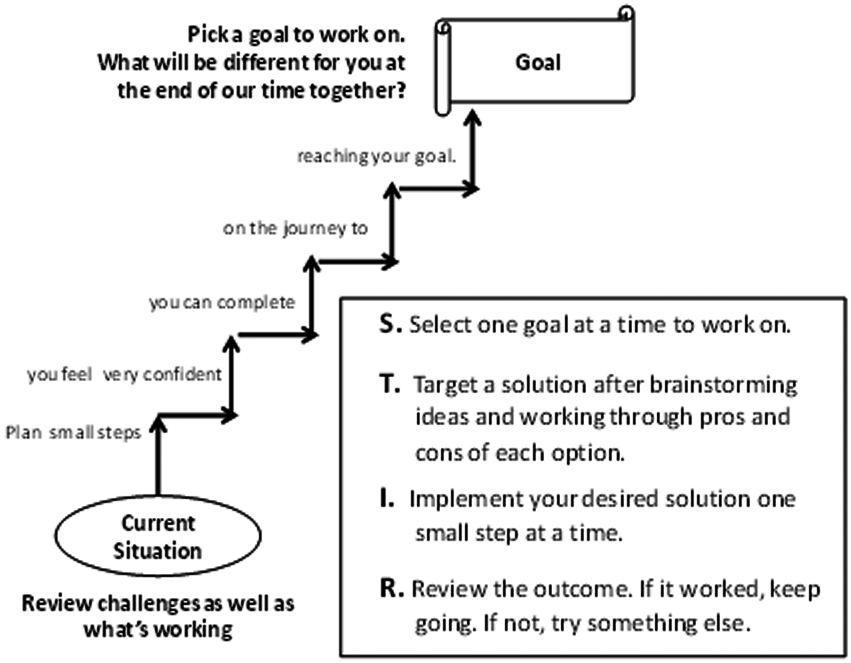


**FIGURE 2. Moving Forward Solution-Building Tool.**

from tasks of observation and prediction, such as simply noticing days or times when they are coping better than other times. Other members might be prepared to take on specific actions.

In order to punctuate further the importance of this time of reflection and looking to the future, a meditation for interested group members, drawn from mindfulness practices (Kabat-Zinn, 1990), closes each session. In some cases, individual group members have led the meditation or shared a favorite relaxation exercise. In the final session, facilitators provide each group member with a signed graduation certificate that includes the "what works" list generated by their specific group.

## Integrating Techniques From Other Approaches with SFT

Beyerbach (2009) and de Shazer and colleagues (2007) noted that many therapeutic techniques are applicable within an SFT framework. The facilitator guide suggests that, based on group preferences and needs, narrative externalizing conversations (White, 2007), CBT exercises (Burns, 1999), simple mindfulness meditations (Kabat-Zinn, 1990), and coaching exercises be used at specific points in the group process.

## OPPORTUNITIES FOR FUTURE WORK

At the time of writing, the group has run four times, including one single-session focus group and three planned four-week groups. The group continues to evolve based on attendee feedback. At the close of each Moving Forward session, caregivers complete the Session Rating Scale (SRS) (Duncan et al., 2003). We modified the SRS slightly from the original based on caregiver input, as shown in Figure 3. The changes include explicitly noting the scale on the SRS and rewording the questions to reflect the group context. Since making early changes to the group structure to include more exercises, evaluations have been consistently at the highest end of the SRS. Attendees have told us the group has been helpful for them and several have encouraged other caregivers to attend.

Evidence gathered so far suggests that the group has been effective. Facilitators have observed examples where solution-focused conversations highlighted caregiver strengths that surprised other professionals working closely with the caregiver. In one very different example, a caregiver who minimized his difficulties as a caregiver at the start of the group was more openly discussing challenges and setting goals to address them by the end of a four-session group. We surmised that the supportive atmosphere of the group enabled him to disclose troubles he might not have been comfortable discussing previously. The modular group structure has proven to be easy

**Evaluation of today's session: Date:_____**

**Please rate today's session by rating each mark on a scale of 0 to 10. Thank you for helping us to continue to improve the group by offering your input.**

| | | |
|---|---|---|
| I felt heard, understood, and respected. | 0 | 10 |
| We worked on or talked about what I wanted to work on and talk about. | 0 | 10 |
| The group's approach is a good fit for me. | 0 | 10 |
| Overall, today's group session was right for me. | 0 | 10 |

Additional Comments (use back of sheet if desired):

**FIGURE 3. Moving Forward Modified Session Rating Scale.**

to learn, adapt, and use by the five facilitators involved to date. Facilitators have also been able to adapt and include new group materials based on caregiver preferences.

The biggest challenge for Moving Forward has been caregiver recruitment and attendance. Hospital staff are already overworked and recruitment is very time-consuming. Caregivers acknowledge the need for support and there is interest in the group, but timing, logistics, and conflicting demands have posed multiple challenges. Admission, medical tests, and discharge schedules rarely align with group timing. A flu outbreak resulted in the cancellation of one session. Caregivers often feel guilty about taking the time for themselves.

Accordingly, recruitment and attendance have been less than we hoped. Over half of caregivers have only been able to attend one or two sessions in the multi-session groups held. Some caregivers told us they found the group helpful, but felt one or two sessions were sufficient. Since the original submission of this paper, the hospital has held two two-week Moving Forward programs following a multi-week stroke education program attended by both stroke survivors and their caregivers. While caregivers attended Moving Forward, the stroke survivors attended a therapeutic recreation program. Recruitment and attendance were excellent both times using this format. Additional exploration of group formats and timing is required.

Moving Forward uses a modular design intended to support multiple formats and applications. We believe the group format to be adaptable for caregivers of those suffering from other problems, particularly for caregivers of adults requiring rehabilitation services due to the sudden onset of illness or disability. The group design also supports a transition out of the hospital environment to supporting caregivers in the community. Other applications could potentially use the same group process, but exercises and the resource package require review to ensure relevance.

Multiple research opportunities exist. The need for stroke caregiver support is large, but there is little intervention research. SFT has proven successful in multiple health care applications and our experience is that SFT is an excellent fit for working with stroke caregivers. Both caregivers and the SFT literature would benefit from systematic research in this area.

There is also value in assessing the impact of interventions like Moving Forward on indirect outcomes such as emergency room visits, readmission rates, and nursing home admissions of the stroke survivor. Pierce, Steiner, Khuder, Govani, and Horn (2009) found their caregiver support and education program lowered emergency room visits and hospital readmissions. Mittelman and colleagues (2007) found counselling interventions for caregivers delayed nursing home placement, thereby reducing health care costs. In our current cost-cutting environment, demonstrating that a caregiver intervention reduces health care costs might help make a case for funding services. Methodology like Crane's (e.g., Crane & Christenson, 2012) that examines the medical offset effect of therapeutic intervention may help persuade funders to invest in such support groups.

Informal caregivers deserve recognition and support both because of their needs and because of the significant amounts of unpaid labor contributed by them to our

economy. Caregiver support will grow in importance as our population ages. The Moving Forward group, with its solution-focused approach and modular design, seems to fit well with the needs of caregivers across multiple settings, while also supporting the needs of busy group facilitators.

## REFERENCES

Beyebach, M. (2009). Integrative brief solution-focused family therapy: A provisional roadmap. *Journal of Systemic Therapies*, *28*(3), 18–35. doi:10.1521/jsyt.2009.28.3.18

Brereton, L., Carroll, C., & Barnston, S. (2007). Interventions for adult family carers of people who have had a stroke: A systematic review. *Clinical Rehabilitation*, *21*, 867–884. doi:10.1177/0269215507078313

Burns, D. D. (1999). *Feeling good: The new mood therapy* (2nd ed.). New York: William Morrow.

Canadian Institute for Health Information. (2010). *Supporting informal caregivers: The heart of home care*. Retrieved April 4, 2012, from http://secure.cihi.ca/cihiweb/products/Caregiver_Distress_AIB_2010_EN.pdf

Crane, D. R., & Christenson, J. D. (2012). A summary report of the cost-effectiveness of the profession and practice of marriage and family therapy. *Contemporary Family Therapy*, *34*(2), 204–216. doi: 10.1007/s10591-012-9187-5

De Jong, P., & Berg, I. K. (2013), *Interviewing for solutions* (4th ed.). Belmont, CA: Brooks/Cole.

de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy.* New York: Haworth.

Duncan, B. L., Miller, S. D., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy*, *3*, 3–12. Retrieved April 12, 2013 from http://www.myoutcomes.com/documents/The_Session_Rating_Scale_Psychometric_Properties_of_a_Working_Alliance_Scale.pdf

Eldred, C., & Sykes, C. (2008). Psychosocial interventions for carers of survivors of stroke: A systematic review of interventions based on psychological principles and theoretical frameworks. *British Journal of Health Psychology*, *13*, 563–581. doi:0.1348/135910707X236899

Fiske, H., & Zalter, B. (2005). A solution-focused group message. *Journal of Family Psychotherapy*, *16*(1–2). doi:10.1300/J085v16n01_32

Franzen-Dahlin, A., Larson, J., Murray, V., Wredling, R., & Billing, E. (2008). A randomized controlled trial evaluating the effect of a support and education program for spouses of people affected by stroke. *Clinical Rehabilitation*, *22*, 722–730. doi:10.1177/0269215508090161

Froerer, A. S., Smock, S. A., & Seedall, R. B. (2009). Solution-focused group work: Collaborating with clients diagnosed with HIV/AIDS. *Journal of Family Psychotherapy*, *20*(1), 13–29. doi:10.1080/08975350802716475

Gaugler, J. (2010). The longitudinal ramifications of stroke caregiving: A systematic review. *Rehabilitation Psychology*, *55*(2), 108–125. doi:10.1037/a0019023

Gingerich, W., Kim, J., Stams, G., & Macdonald, A. (2011). Solution-focused brief therapy outcome research. In C. Franklin, T. Trepper, W. Gingerich, & E. McCollum (Eds.), *Solution-focused brief therapy: A handbook of evidence based practice* (pp. 95–111). New York: Oxford University Press.

Glasdam. S., Timm, H., & Vittrup, R. (2010). Support efforts for caregivers of chronically ill persons. *Clinical Nursing Research*, *19*(3), 233–265. doi:10.1177/1054773810369683

Grant, A. M. (2012). Making positive change: A randomized study comparing solution-focused vs. problem-focused coaching questions. *Journal of Systemic Therapies*, *31*(2), 21–35. doi:10.1521/jsyt.2012.31.2.21

Green, S. (2011). Solution-focused life coaching. In C. Franklin, T. Trepper, W. Gingerich, & E. McCollum (Eds.), *Solution-focused brief therapy: A handbook of evidence based practice* (pp. 342–353). New York: Oxford University Press.

Heart and Stroke Foundation (n.d.). *Statistics*. Retrieved April 4, 2012, from http://www.heartandstroke.com/site/c.ikIQLcMWJtE/b.3483991/k.34A8/Statistics.htm#stroke

Kabat-Zinn, J. (1990). *Full catastrophe living. Using the wisdom of your body and mind to face stress, pain and illness.* New York: Bantam Doubleday Dell.

King, R. B., Ainsworth, C. R., Ronen, M., & Hartke, R. J. (2010). Stroke caregivers: Pressing problems reported during the first months of caregiving. *Journal of Neuroscience Nursing*, *42*(10). 301–311. doi:10.1097/JNN.0b013e3181f8a575

Kondrat, D., & Teater, B. (2010). Solution-focused therapy in an emergency room setting: Increasing hope in persons presenting with suicidal ideation. *Journal of Social Work*, *12*(1), 3–15. doi:10.1177/1468017310379756

Kranswick, K. I., & Dosman, D. (2008). *Eldercare: What we know today.* Retrieved April 4, 2012 from http://www.statcan.gc.ca/pub/11-008-x/2008002/article/10689-eng.pdf

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Lee, J., Soeken, K., & Picot, S. (2007). A meta-analysis of interventions for informal stroke caregivers. *Western Journal of Nursing Research*, *29*(3), 344–356. doi:10.1177/0193945906296564

Legg, L., Quinn, T., Mahmood, F., Weir, C., Tierney, J., Stott, D., . . . Langhorne, P. (2011). Non-pharmalogical interventions for caregivers of stroke survivors. *The Cochrane Collaboration*, *10*, 1–56. doi:10.1002/14651858.CD008179

Lutz, B. J., & Young, M. E. (2010). Rethinking intervention strategies in stroke family caregiving. *Rehabilitation Nursing*, *35*(4), 152–160. doi:10.1002/j.2048-7940.2010.tb00041.x

McCollum, E. E., Trepper, T. S., & Smock, S. (2003). Solution-focused group therapy for substance abuse: Extending competency based models. *Journal of Family Psychotherapy*, *14*(4), 27–42. doi:10.1300/J085v14n04_03

McKeel, J. (2011). What works in solution-focused brief therapy: A review of change process research. In C. Franklin, T. Trepper, W. Gingerich, & E. McCollum (Eds.), *Solution-focused brief therapy: A handbook of evidence based practice* (pp. 130–143). New York: Oxford University Press.

Mittelman, M. S., Roth, D. L., Clay, O. J., & Haley, W. E. (2007). Preserving health of Alzheimer caregivers: Impact of a spouse caregiver intervention. *American Journal of Geriatric Psychiatry*, *15*(9), 780–789. doi:10.1097/JGP.0b013e31805d858a

Ontario Stroke Network. (2010). *Family informal caregiver stroke self-management research project*. Retrieved April 4, 2012 from http://www.supportingfamilycare.com/uploads/docs/Stroke_Self-Management

Palmer, S. (2007). PRACTICE: A model suitable for coaching, counselling, psychotherapy and stress management. *Coaching Psychologist*, *3*(2), 71–77. Retrieved on December 20, 2012 from https://docs.google.com/viewer?url=http%3A%2F%2Fac.somcom.co.uk%2Fmedia%2Fuploads%2Fpapers%2FThe_PRACTICE_model_of_coaching_towards_a_solution-focused_approach-2.pdf

Parag, V., Hackett, M. L., Yapa, C. M., Kerse. N., McNaughton, H., Feigin, V. L., & Anderson, C. S. (2008). The impact of stroke on unpaid caregivers: Results from the Auckland regional community stroke study. *Cerebrovasular Diseases*, *25*(6), 548–554. doi:10.1159/000131673

Pierce, L., Steiner, V., Khuder, S., Govoni, A., & Horn, L. (2009). The effect of a web-based stroke intervention on carers' well-being and survivors' use of healthcare services. *Disability Rehabilitation*, *31*(20), doi:10.1080/09638280902751972.911800154

Postma, K., & Rao, N. S. (2006). Using solution-focused questioning to facilitate the process of change in cognitive behavioural therapy for food neophobia in adults. *Behavioural and Cognitive Psychotherapy*, *34*, 371–375. doi:10.1017/S1352465806002979

Quick, E., & Gizzo, D. (2007). The "doing what works" group: A quantitative and qualitative analysis of solution-focused group therapy. *Journal of Family Psychotherapy*, *18*(3), 65–84. doi:10.1300/J085v18n03_05

Sage, N., Sowden, M., Chorlton, E., & Edeleanu, A. (2008). *CBT for chronic illness and palliative care: A workbook and toolkit*. Chichester, England: Wiley.

Sharry, J. (2008). *Solution focused groupwork*. London: Sage.

Silva-Smith, A. (2007). Restructuring life: Preparing for and beginning a new caregiving role. *Journal of Family Nursing*, *13*(1), 99–116. doi:10.1177/1074840706297425

Simon, J. (2010). Solution-focused practice in end-of-life and grief counselling. New York: Springer.

Smock, S. A., Trepper, T. S., Wetchler, J. L., McCollum, E. E., Ray, R., & Pierce, K. (2008). Solution-focused group therapy for level 1 substance abusers. *Journal of Marital and Family Therapy, 34*(1), 107–120. doi:10.1111/j.1752-0606.2008.00056.x

Thorslund, K. W. (2007). Solution-focused group therapy for patients on long-term sick leave: A comparative outcome study. *Family Psychotherapy*, *18*(3), 11–24. doi:10.1300/J085v18n03_02

Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2008). *Solution-focused therapy treatment manual for working with individuals research committee of the solution focused brief therapy association.* Retrieved September 8, 2012 from http://www.sfbta.org/Research.pdf

Vogelaar, L., van't Spijker, A., Vogelaar, T., Busschbach, J. J., Visser, M., Kuipers, E., & van der Woude, C. J. (2011). Solution-focused therapy: A promising new tool in the management of fatigue in Crohn's disease patients: Psychological interventions for the management of fatigue in Crohn's disease. *Journal of Crohn's and Colitis, 5*, 585-591. doi:10.1016/j.crohns.2011.06.001

White M. (2007). *Maps of narrative practice*. New York: W. W. Norton.

Copyright of Journal of Systemic Therapies is the property of Guilford Publications Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.