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An exploratory study of the usefulness of solution -focused brief therapy groups with elementary school children

Jennifer Clevenger Demmons
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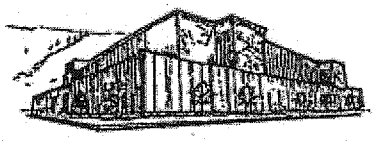

AN EXPLORATORY STUDY OF THE USEFULNESS OF SOLUTION-FOCUSED BRIEF THERAPY GROUPS WITH ELEMENTARY SCHOOL CHILDREN

by

Jennifer Clevenger Demmons

M.A. University of Montana, 1997

M.A. University of Montana, 2000

Ed.S. University of Montana, 2000

Presented in partial fulfillment of the requirements

for the degree of Doctorate in Education

The University of Montana

2003

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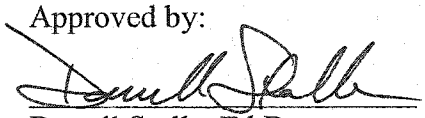

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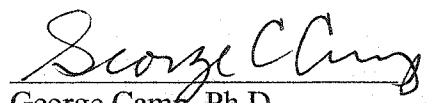

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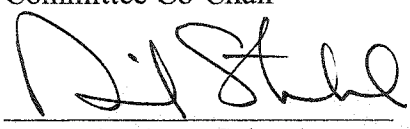

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Demmons, Jennifer C., Ed.D. May, 2003 Counseling

An Exploratory Study of the Usefulness of Solution-Focused Brief Counseling Groups with Elementary School Children

Co-Chairman: Darrell Stolle, Ed.D.
Co-Chairman: George Camp, Ph.D.

This study qualitatively explored the usefulness of solution-focused brief therapy (SFBT) groups with elementary school children by exploring its perceived effects on a group of elementary school children. A triangulating approach was utilized in gathering both quantitative and qualitative data regarding a single SFBT group composed of seven purposefully sampled students from a single rural elementary school. These students experienced six sessions of SFBT group therapy once a week for 45 minutes a session, with the researcher acting as group leader.

Data from five students were ultimately included in analysis, and this information included: process notes and general observations of the researcher; BASC checklists from parents, teachers, and children pre- and post-group; teachers' informal behavior rating scales pre- and post-group; children's goal attainment ratings pre-group and each session; and one-on-one exit interviews. These interviews were audiotaped, transcribed, and then color-coded for relevant themes.

The data were examined using an inductive process of case study analysis advocated by Stake (1997) and Cresswell (1997) involving: description of the case, direct interpretation, categorical aggregation, searching for patterns, and making naturalistic generalizations.

Analysis resulted in a number of findings. First, the group experience was perceived to be a positive one by the children. Second, every child reported goal attainment, and three children indicated statistically significant improvement on their BASC self-reports. Although parents and teachers did not report statistically significant change on their BASCs, teachers still viewed qualitative behavioral improvement in those students initially seen as having classroom difficulties. Third, evidence of macrolevel effects (e.g. empowerment, systemic behavioral change, or generalization of solution-oriented techniques to other problems) was mixed. Fourth, themes of therapeutic factors common to group work were evidenced in the interview transcripts.

This study concluded that SFBT groups may be a useful technique to use in schools, depending on the counselor and the context, but there appears to be no qualitative difference between the solution-focused approach and the traditional problem-solving paradigm. Suggestions were made that future research delve further into "common factors" shared among successful therapy approaches and the effects of different therapy models on counselors.

ACKNOWLEDGMENTS

The successful completion of this dissertation and the long personal journey that it has represented would not have been possible without the contributions of many individuals.

I am foremost indebted to my family for their support and sacrifices along the way. Special thanks to my husband, Chris, for his pep talks and errand-running without complaint--and to my children, Gabe and Lauren, for allowing Mom to pursue the dream.

Dr. Darrell Stolle and Dr. George Camp provided me their insightfulness, expertise, guidance, and encouragement, for which I am extremely grateful. Thanks also to the other members of my committee--Dr. Roberta Evans, Dr. Cathy Jenni, and Dr. Rita Sommers-Flanagan--for their helpful suggestions and thought-provoking discussions. This group of mentors has challenged me to better myself and has served as models to aspire to.

My journey continues...

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CHAPTER ONE

Introduction

Context

The role of the elementary school counselor is a multifaceted, complex, often challenging one. Typical duties usually involve providing individual and group counseling; consultation to teachers, parents, and administrators; classroom psychoeducation and vocational guidance; and coordination of group testing. Such demands can limit school counselors' time and resources (Mostert, Johnson, & Mostert, 1997; Downing & Harrison, 1992; Sklare, 1997). In Sklare's (1997) opinion, most counselor education programs place an emphasis on traditional, long-term therapies that may be unrealistic to implement given the realities of the school setting. Unfortunately, many school counselors have reported feeling that their graduate training programs did not adequately prepare them for the "real world" demands of the job (Mostert et al., 1997; Downing & Harrison, 1992).

DeJong & Berg (1998) feel that the majority of mental health training programs teach their students to follow a traditional problem-focused approach to therapy involving the following steps: a) describing the problem and collecting data, b) assessing the problem, c) coming up with an intervention plan, d) implementing the intervention, and d) evaluating the intervention(s) and follow-up. Furthermore, some feel the interventions usually implemented in school settings by mental health professionals involve direct approaches that seek to teach new behaviors. Kral (1986) believes that such interventions "are well-accepted in schools because they are consistent with a philosophy that values

teaching something new, much like teaching 6-year-olds to read" (p. 56). However, the direct problem-solving approach can be time-consuming and does not address the fact that most students receiving school counseling services are not self-referred (Kral, 1994; Downing & Harrison, 1992) and may not wish to be taught any new skills (Kral, 1986).

Granted the time constraints most school counselors face, brief therapies have recently gained attention as a viable option in the school setting (Amatea, 1989). However, most brief therapies follow a problem-solving approach that focuses on deficits (Murphy, 1996; Stone, 1995; Kral, 1986). Solution-focused brief therapy is one alternative to the traditional problem-solving paradigm (DeJong & Berg, 1998).

Solution focused brief therapy (SFBT, also referred to as solution-focused brief counseling and solution-oriented therapy in the literature), was developed by de Shazer and colleagues in the 1970s at Milwaukee's Brief Family Therapy Center. Although SFBT was first conceptualized as a family therapy model, it has recently expanded to the school setting (Rhodes, 1993), including individual counseling (e.g. Murphy, 1994); group counseling (e.g. LaFountain & Garner, 1996; LaFountain, Garner, & Eliason, 1996; Sklare, 1997); classroom guidance (e.g. Cook, 1998), and consultation (e.g. Durrant, 1995).

The SFBT model differs from other brief therapies in that it advocates a postmodern approach to counseling that emphasizes client strengths and "what works" (Durrant, 1995; Huber & Backlund, 1991; de Shazer, 1986). Rather than assuming the problem resides in the individual, SFBT takes the constructivist

view where problems are seen as resulting from interactional patterns between the individual and his/her environment (Murphy, 1996). Therefore, the problem is externalized rather than attributed to internal characteristics of the individual experiencing the difficulty. Given its postmodern philosophical foundation, SFBT is perceived by its proponents as more positive, respectful, and empowering for clients than problem-solving therapies (DeJong & Berg, 1998; Chevalier, 1995; Greene, Lee, Mentzer, Pinnell, & Niles, 1998).

Solution-focused brief therapy in the form of group counseling may provide even further benefits to clients and counselors than individual SFBT. Many therapists (e.g. Corey & Corey, 1997; Yalom, 1995) perceive group therapy as potentially offering more therapeutic advantages than individual counseling. Corey & Corey (1997) state:

> From our perspective, groups are the treatment of choice, not a second-rate approach to helping people change. Many of the problems that bring people to counseling are interpersonally rooted and involve difficulties in forming or maintaining intimate relationships. Clients often feel that their problems are unique and that they have few options to get out of deadening ruts. They may be at a loss in knowing how to live well with the ones they love. Groups provide a natural laboratory that demonstrates to people that they are not alone and that there is hope for creating a different life. (p. 5)

Both Corey and Corey (1997) and Yalom (1995) discuss the importance of "interpersonal learning" (Yalom, p. 17) and describe similar stages of group development and important therapeutic factors involved in group process. Solution-focused groups reportedly follow a similar progression of developmental stages (Coe & Zimpfer, 1996; LaFountain & Garner, 1995) and involve the same therapeutic factors described by Yalom (Coe & Zimpfer, 1996). Thus, "a combination of solution-oriented interventions and the use of group counseling represents the best of both worlds, in the sense that they offer many possibilities for inducing positive results" (Coe & Zimpfer, 1996, p. 50).

Furthermore, SFBT may offer specific advantages to school counselors. LaFountain and colleagues (LaFountain, Garner; & Boldosser, 1995; LaFountain & Garner, 1996; LaFountain, Garner, & Eliason, 1996) argue that SFBT groups overcome many of the obstacles counselors typically face when trying to provide group counseling services to students, such as scheduling problems, "time constraints, lack of role models, misunderstanding of the group process by teachers and parents, and labeling of children" (LaFountain et al., 1995, p. 41). Whereas counselors following a problem-solving approach would usually form groups of students all working on similar issues, SFBT groups may include students working on a variety of topics because the process of looking for solutions is believed to be the same for any problem. As LaFountain et al. (1996) state:

> Solution-focused counseling lends itself to forming heterogeneous groups. As students in the group see other members applying

> similar solutions to a variety of difficulties, they can more readily generalize "keys to solutions" to a variety of situations. This allows counselors to overcome many of the obstacles associated with establishing homogeneous groups. (p. 257)

With heterogeneous groups of children, scheduling becomes a less significant problem because counselors can transfer students on their existing caseloads into SFBT groups. Such groups also avoid stigmatizing labels (e.g. "anger management group," and "children of divorce group").

Unfortunately, little empirical research has been conducted on the use of SFBT in general, let alone in schools (Miller, 1994). Of the handful of published studies done in educational settings, most of these have been at the junior high and high school level (e.g. Littrell, Malia, & Vanderwood, 1995). Excluding anecdotal reports, only LaFountain and colleagues' SFBT group research (LaFountain, Garner; & Boldosser, 1995; LaFountain & Garner, 1996; LaFountain, Garner, & Eliason, 1996) and a doctoral dissertation by Cook (1998) on using SFBT elements in a classroom guidance unit have addressed the use of SFBT with elementary children in a school setting as of the time of this writing. Thus, the present study sought to explore the effects of SFBT groups on this population in this environment.

Statement of Purpose

Given the multiple benefits ascribed to SFBT and because little research has been done in this area to date, this study's purpose was to better understand the effects of an SFBT group experience on elementary school children. This

paper does not argue that SFBT replace all other forms of therapeutic intervention in schools. Rather, the usefulness of SFBT as an additional tool in the counselor's repertoire of therapeutic techniques was examined with the hope of raising relevant research questions for future study.

Grand Tour Question and Subquestions

The guiding question for this research proposal was: What are the perceived effects of SFBT groups on elementary school children? By answering this over-arching question, it was believed some evaluation could be made of the usefulness of SFBT with elementary school children. However, given the model's postmodern foundation with the core belief that reality is constructed at the individual and the social level (Hayes & Oppenheim, 1997), as well as Yalom's (1995) observation that the microcosm of the group reflects the larger social picture, the grand tour question was broken down into subquestions that reflected an interest at the both the individual (microlevel) and the larger social level (macrolevel).

- What were the general perceptions of the children toward the SFBT group process? Would these perceptions support assertions made about SFBT producing perceptions of empowerment?
- Was the group experience sensed to be a positive one?
- Were personal goals perceived to be attained?
- Did the child perceive positive change in behavior(s) associated with the problem and/or goal, pretreatment and/or overall?

By answering each of these questions for the individual child, it was believed some judgment could be made about the usefulness of the group as a whole.

The following research questions were important at the macrolevel:

- Were the children able to generalize what they learned in the group to other problems?
- Did any self-perceived behavioral changes extend to behaviors not directly associated with the problem and/or goal?
- Did parents and teachers perceive desirable behavioral change?

Definition of Terms

The following terms used in this study warrant clarification:

- Categorical aggregation: "an aspect of data analysis in case study research where the researcher seeks a collection of instances from the data, hoping that issue relevant meanings will emerge (Stake, 1995)" (Cresswell, 1998, p. 249).
- Case study: "in qualitative research, this is the study of a 'bounded system' with the focus being either the case or an issue that is illustrated by the case (or cases) (Stake, 1995). A qualitative case study provides an in-depth study of this 'system,' based on a diverse array of data collection materials, and the researcher situates this system within its larger 'context' or setting" (Cresswell, 1998, p. 249).
- Constructivism: "shares a 'negative identity' [with social constructionism, see below] deriving from their repudiation of traditional ontological assumptions (bearing on the nature of 'reality') and epistemological frameworks (bearing

on the nature of knowledge)" (Neimeyer & Raskin, 2000, p. 5). However, constructivism differs in its emphasis on personal relationships, metaphors, and stories while placing less emphasis on social-level constructions of reality.

- Compliments: "affirmations" of what the client is doing well in his/her life (DeJong & Berg, 1998, p. 109).
- Description: "stating the 'facts' about the case as recorded by the investigator. This is the first step in analysis of data in a qualitative case study, and Stake (1995) calls it 'narrative description'" (Cresswell, 1998, p. 250).
- Direct interpretation: "an aspect of interpretation in case study research where the researcher looks at a single instance and draws meaning from it without looking for multiple instances of it. It is a process of pulling the data apart and putting them back together in more meaningful ways" (Cresswell, 1998, p. 250).
- Empiricism: "with historical roots in the philosophies of Locke, Berkley, and Hume, an empiricist approach to knowledge is based on the assumptions that all knowing derives from experience (or through the senses) and reflects a gradual process of discovering and internalizing a relatively stable external reality" (Lyddon, 1995, p. 580).
- Epistemology: "the study of knowledge and knowing and is concerned with basic questions related to the origins, nature, limits, and validity of knowledge" (Lyddon, 1995, p. 579).

- Exceptions: "those past experiences in a client's life when the problem might reasonably have been expected to occur but somehow did not" (DeJong & Berg, 1998, p. 95).
- Formula first session task: SFBT homework task typically given after the first session to clients who need assistance in developing well-formed goals and asks the client to notice what happens around them that they would like to continue to have happen.
- Mindmapping: "refers to the creation of a road map of thoughts that guides individuals to their destination" (Sklare, 1997, p. 47).
- Ontology: "a philosophical assumption about the nature of reality" (Cresswell, 1998, p. 254).
- Outcome research: research that "evaluates the effectiveness of therapy. Typically, outcome studies summarize the results (outcome) of clients receiving treatment based on one model of therapy, or they compare the outcome of two or more treatment models" (McKeel, 1996, p. 251).
- Naturalistic generalizations: "in the interpretation of a case, an investigator undertakes a case study to make the case understandable. This understanding may be what the reader learns from the case or its application to other cases (Stake, 1995)" (Cresswell, 1998, p. 251).
- Paradigm: "a model or pattern... a recognized way of thinking within a scientific discipline that provides, for a time, the essential questions and answers for researchers in that field" (Schultz and Schultz, 1992, p. 19).

- Poly-ocular social perception: Bateson's theory that ideas emerge "from having two or more descriptions of the same process, pattern, system, or sequence that are coded or collected differently" (de Shazer, 1985, p. 19).
- Postmodernism: a family of theories and perspectives sharing the ideological perspective asserting that "knowledge claims must be set within the conditions of the world today and in the multiple perspectives of class, race, gender, and other group affiliations" (Cresswell, 1998, p. 255).
- Pretreatment change: the change that occurs between the client's initial contact with the therapist (usually the call to make an appointment) and the time of the first session.
- Problem-focused paradigm: the traditional overarching framework for most mental health professionals which guides the therapeutic process and is based on the medical model; it involves the following steps: a) describing the problem and collecting data, b) assessing the problem, c) coming up with an intervention plan, d) implementing the intervention, and d) evaluating the intervention(s) and follow-up (DeJong & Berg, 1998).
- Process research: studies that "often examine the immediate or long-term impact of a particular therapeutic intervention or strategy" (McKeel, 1996, p. 254).
- Rational supremacy: "the assertion that reason and the higher intellectual processes should rule over feelings and voluntary behavior...knowing is essentially a deductive process whereby ideas of reason and logic are the primary sources of objective knowledge" (Lyddon, 1995, p. 579).

- Ripple effect: an assumption in SFBT that one small change on the part of the individual can lead to larger changes throughout that person's social system because other people adjust their responses in accordance to the new behavior, which is in turn met with more new behaviors on the individual's part (*e.g.* Sklare, 1997).
- Social constructionism: a postmodern theory emphasizing "the social as opposed to individual origins of meaning" and focusing "on discursive practices as opposed to individual cognitions as the objects of study, critique, and transformation. In social constructionism, what it means to be a person is determined by cultural ways of talking about and conceptualizing personhood" (Neimeyer & Raskin, 2000, p.6).
- Solution-focused brief therapy: a constructivist therapeutic model developed by DeShazer and colleagues at the Brief Family Therapy center in Milwaukee, advocating an optimistic, strengths-based approach to counseling.
- Solution-talk: talk that focuses on and amplifies change (McKeel, 1996).
- Utilization principle: Milton Erickson's theory that people possess within themselves the tools for change (Durrant, 1995).

Delimitations

This study was delimited to fourth, fifth, and sixth graders referred for counseling at a small rural school in Western Montana (approximately 700 elementary students). Furthermore, children who were known to have conditions contraindicating group counseling were excluded from consideration in the

research project. Finally, the group subjects were delimited to those not receiving outside private therapy. Thus, subjects were purposefully chosen for this study.

Limitations

Because this inquiry is an exploratory case study of a single SFBT group with upper-elementary students from a single rural school, it is limited in its generalizability. This research is also limited in that the researcher led the SFBT groups, gathered all information, and interpreted the data. The conclusions drawn from this research are the perceptions of the researcher, filtered and shaped by the researcher's background and biases, and others may interpret these findings differently. However, the researcher's co-chairs provided a check on the researcher's findings as a method of improving validity.

This study's findings may also be limited by the researcher's pre-existing and ongoing relationships with the students and staff members involved in this study, as there may have been some expectancy bias for the group to lead to positive change.

Significance

As mentioned above, grand generalizations have been made regarding SFBT with little research having been conducted on the use of SFBT with children. Results of SFBT research conducted with adult populations should not be generalized to children for obvious reasons, but particularly so given that SFBT is a highly cognitive type of therapy and young children may struggle with some of the more intellectual and abstract concepts involved (Selekman, 1997).

This study sought to explore the effects of school SFBT groups on upper elementary students.

Furthermore, SFBT research has been soundly criticized (e.g. Stalker, Levene, & Coady, 1999; Miller, 1994; Corcoran & Stephenson , 2000) for focusing heavily on the use of self-report measures to assess therapy success. Nichols and Schwartz (as cited in Stalker et al., 1999) call this evaluative approach "'about as substantial as the usual response to the waiter's question, "How was everything?"'" (p. 470).

In reviewing SFBT research, Miller (1994) found:

> The majority of claims...were substantiated solely by reference to "clinical subjective experience" usually related in the context of stories and anecdotes about successful uses of the solution-focused, solution-oriented models.... No empirical studies, in the traditional sense of the word 'empirical,' had ever been conducted and indeed, there seemed to be an underlying attitude of cynicism and distrust of such research in much of the writing...(pp. 21-22).

In reviewing some of the preliminary research on SFBT, Corcoran and Stephenson (2000) commented that baseline data was rarely collected and that telephone interviews and nonstandardized measures had been major methods of data collection.

To address some of these concerns, the proposed study leaned heavily on methodological triangulation, an approach involving the cross-check of multiple data sources (Stake, 1995). "With multiple approaches within a single study, we

are likely to illuminate or nullify some extraneous influences" (Stake, 1995, p. 114). First, standardized instruments with well-supported validity and reliability were utilized in collecting quantitative broad-band social/emotional/behavioral data based on the observations of parents, teachers, and the children. Second, teachers provided narrow-band quantitative scale-ratings of their behavioral observations of the children before and after the group. Third, in order to weigh "subjective clinical experience" against standardized measures of behavioral change, self-report measures were also utilized. These self-report measures were ratings of goal attainment taken prior to the group and during each session, and an exit interview that was qualitatively analyzed for themes. Fourth, the researcher's personal observations and process notes of each group were considered. Finally, the collected data were analyzed using an over-arching qualitative approach advocated by Stake (1997) to assess the perceived effects of the SFBT group on the children.

CHAPTER TWO

Review of Related Literature

Introduction

The developmental course of psychology as a science has been marked by the emergence of numerous ideological groups. According to Schultz and Schultz (1992), these competing "schools of thought" have kept psychology in the pre-paradigmatic stage of scientific development. These authors describe the Kuhnian construct of paradigm as "a model or pattern... a recognized way of thinking within a scientific discipline that provides, for a time, the essential questions and answers for researchers in that field" (p. 19). Schultz and Schultz (1992) argue that psychology is not yet a paradigm because "no single system or point of view has yet succeeded in unifying the various positions" (p. 19).

However, DeJong & Berg (1998) perceive modern psychology as indeed unified under a problem-solving paradigm characterized by certain commonalties shared among most major psychological schools of thought. These authors view the problem-solving paradigm as having inherent shortcomings and advocate a solution-focused, strengths-based paradigm instead.

Difficulties Inherent in the Problem-Solving Paradigm

DeJong and Berg (1998) view the problem-solving paradigm as unified by two underlying factors: a) a problem-solving approach, and b) a reliance on expertise.

Problem-Solving Approach

The helping professions have been strongly influenced by the medical model of abnormal behavior (Craighead, Craighead, Kazdin, & Mahoney, 1994; Christensen, Todahl, & Barrett, 1999). In this model, physicians diagnose an individual's pathology, whether psychological or physical, in order to derive a course of treatment. The problem-solving approach of the helping professions has likewise viewed the problem and its solution as necessarily linked—the diagnosis determines the treatment (DeJong & Berg, 1998). Treatment is defined as "successful" if the symptoms of the disorder improve.

As defined above, a paradigm dictates the essential questions of the field and how they are to be answered. DeJong and Berg (1998) describe McMahon's problem-solving formula as indicative of the guiding framework for the helping professions. McMahon's problem-solving stages are summarized as follows:

Description of problem(s) and data collection. The client describes the problem(s) while the practitioner asks follow-up questions for clarification. DeJong and Berg (1998) have identified three types of questions often employed in the problem-solving approach: a) questions that attempt to narrow down the problem; b) questions that imply that an alternative course of action should have been taken (and, thus, place blame on the client); and c) questions aimed at getting to the root cause of the problem.

Problem assessment. Once enough information is collected, the practitioner then uses the professional knowledge base to diagnose the problem.

Intervention. Interventions are selected based on the diagnosis. The intervention strategies are carried out.

Evaluation and follow-up. Progress of goal-attainment is monitored and evaluated. If the goals are not being met, it is assumed that a mistake occurred at a previous stage (e.g. the problem was misdiagnosed or different interventions are indicated). The practitioner may go back to any stage in the process and begin again. Services end when the client and practitioner both view the problem as solved.

Reliance on Expertise

Because various problems are seen as calling for different solutions, the helping professional is placed in the role of "expert" in terms of assessment, diagnosis, and treatment of the problem; the problem itself is viewed as having an objective reality distinct and independent of the knower.

The two unifying factors described above may be further elucidated by examining the problem-solving paradigm's epistemological assumptions.

Epistemology of the Problem-Solving Paradigm

Lyddon's (1995) epistemological examination of modern cognitive theories of knowing resulted in his identifying two assumptions inherent in these theories.

First, Lyddon noted that many cognitive theories rely on "the doctrine of *rational supremacy*—the assertion that reason and the higher intellectual processes should rule over feelings and voluntary behavior...knowing is essentially a deductive process whereby ideas of reason and logic are the primary

sources of objective knowledge" (p. 579). Standards of logic and rationality are often used in the problem-solving paradigm to determine whether or not an individual is psychologically well-adjusted.

Secondly, Lyddon noted a commitment to empiricism, the belief that knowledge is derived from the environment through the senses. It is assumed that "knowledge validly reflects the degree to which perceptions reliably map the objective world of verifiable observations" (p. 580). Under this assumption, a person is considered psychologically well-adjusted when his/her perceptions of the external reality are in keeping with what is considered true and valid.

Although Lyddon limited his discussion to cognitive theories, Neimeyer & Raskin (2000) state that:

> For most of the 20th century, this objectivist orientation has held sway in the allied fields of psychotherapy and psychotherapy research, forming a common program endorsed by many proponents of psychodynamic, cognitive-behavioral, and humanistic psychology, despite their manifest differences. (p. 5)

Thus, the underlying assumptions Lyddon discussed may be generalized to the problem-solving paradigm as a whole.

The Problem-Solving Approach in Schools

According to Murphy (1996), a problem-solving, deficit-based approach is currently the guiding paradigm within the U.S. school system. For example, school psychologists have always employed some variation of problem-solving in assessing children for special education services and then generating

interventions—the focus of the approach has simply shifted over time from the individual child to a more ecological perspective (Fagan, 1995). Such a systemic emphasis has resulted in school counselors and school psychologists increasing consultation with teachers and parents, and consultation is nothing other than a collaborative problem-solving process involving the following stages: "1. Problem/Situation Analysis; 2. Goal Identification; 3. Strategy Development and Implementation; 4. Evaluation" (Curtis & Stollar, 1995, p. 54). These steps are strikingly similar to McMahon's problem-solving steps described above.

However, the deficit-focused, problem-solving paradigm within schools is coming under increasing fire (e.g. Murphy, 1996; Stone, 1995). Murphy (1996) contends that the prevailing deficit-based model in schools leads to the assumption "that students referred for services are somehow deficient or lacking in the necessary motivation or skills to change" (p. 184). If referred students already perceive "the world is against them," such a perspective may drive many away (Downing & Harrison, 1992, p. 328).

Also, some believe that it is much easier to build on existing strengths and resources than to get someone to adopt a completely new behavior set (Murphy, 1996; Chevalier, 1995), particularly when the client is resistant to change. As mentioned above, many students do not wish to learn new skills or try new behaviors (Kral, 1986).

SFBT Described

Theoretical Foundations

Erickson. The development of SFBT has been greatly influenced by a number of sources. One of these is the work of Milton Erickson, particularly his utilization principle, which specifies that people possess within themselves the tools for change (as cited in Lawson, 1994; as cited in Rhodes, 1993; as cited in de Shazer, 1985). Rather than trying to correct clients by ameliorating underlying pathology, the focus is on client strengths, what the client is already doing that works. "The key [to SFBT is] utilizing what the client brings with him to meet his needs in such a way that the client can make a satisfactory life for himself" (de Shazer, 1985, p.6).

Bateson. De Shazer was also greatly interested in the work of Bateson, whose theory of poly-ocular social perception influenced the Milwaukee group to often use a team approach in therapy. Bateson believed that ideas emerge "from having two or more descriptions of the same process, pattern, system, or sequence that are coded or collected differently" (de Shazer, 1985, p. 19). No one perception is viewed as superior. Ideas emerge as a consequence of the differences among perceptions.

Although Bateson was an initial philosophical influence on SFBT, some proponents of the model began to question Bateson's treatment of information as objective reality (e.g. Walter & Peller, 1996). Walter and Peller (1996) exemplify the shifting emphasis of the SFBT movement in the following statement:

> The language of conversation, narrative, reflections, and text has become more relevant to our approach than the language of observation, interview, information, and feedback. This different philosophy of language has provided the hinge of change for us as we have made many fundamental shifts in our assumptions. (p.11)

Constructionism and constructivism. Epistemologically, the SFBT model greatly relies on Gergen's theory of social constructionism (discussed in Lyddon, 1995), as well as personal constructivism (Durrant, 1995). Neimeyer & Raskin (2000) differentiate between the postmodern theories of social constructionism and constructivism in terms of their emphases. In contrast to rational supremacy and empiricism, social constructionism views knowledge as a creation of the social process rather than residing in the individual. Meaning is collaboratively co-created within social groups based on the meaning's pragmatic value in the immediate cultural context. Meaning (i.e. reality) changes in accordance with cultural changes (Lyddon, 1995). Such an epistemology is viewed as empowering the client.

According to Neimeyer & Raskin (2000), constructivism "shares a 'negative identity' [with social constructionism] deriving from their repudiation of traditional ontological assumptions (bearing on the nature of 'reality') and epistemological frameworks (bearing on the nature of knowledge)" (p. 5). However, constructivism differs in its emphasis on personal relationships, metaphors, and stories while placing less emphasis on social-level constructions of reality.

Neimeyer & Raskin (2000) describe narrative theory as incorporating both elements of social constructionism and personal constructivism, and Lyddon (1995) touts narrative therapy as an example of social constructionism and empowerment at work in mental health. The goal of narrative therapy is not to correct the client, but for client and therapist to co-create narratives—complex representations of meaning that change over time (Vogel, 1994)—until the problem(s) perceived by the client are no longer experienced as such. Rhodes (1993) identified the narrative therapy of White and Epston as essentially a solution-focused approach, and, indeed, SFBT does recognize the importance of the client's use of language and meaning in the therapeutic process:

> One of the contributions of interactional approaches to therapy has been the notion that people's experience is greatly influenced by the contexts in which they live... "Reality" is not a fixed, static given. It is influenced by our cultures and the interactions we have with one another. It is influenced by the language we speak, the words we use, the world views that we share that are reflected in those words. It is with this in mind that we stress that therapy is a little culture or society created in the session. This culture will, in our view, greatly influence client's feelings, thoughts, reports, and perceptions. (O'Hanlon & Weiner-Davis, 1989, p.55)

Thus, SFBT incorporates the notion of meaning-construction on both the macro-level (e.g. larger social groups and family) and the micro-level (e.g. the therapist-client relationship). De Shazer and Miller (1998) have even metaphorically

described solution-focused therapy as "a rumor" circulating among the mental health community and explain how SFBT "involves socially constructing new stories for clients' lives" (p. 365).

Strategic family therapy. Strategic family therapy, or problem-focused therapy, was developing at the Mental Research Institute (MRI) in Palo Alto around the same time that de Shazer was developing his own model. Quick (1996) contends that "solution focused therapy began as a variant on the MRI approach" (p. 6), and Rhodes (1993) claims that MRI had an "indirect and rather conceptual" influence on SFBT (p. 27).

Instead of concentrating on the "why" of a problem, strategic family therapists focus on the process of the problem in terms of family patterns of interaction. A solution to the problem is sought by changing key familial patterns in a brief time frame—no longer than 10 sessions (O'Hanlon & Weiner-Davis, 1989; Amatea, 1989). De Shazer was likewise interested in brief therapy and patterns of family interactions, but he was looking to "'solution patterns' and how to expand and amplify these" (Rhodes, 1993, p. 28).

Basic Assumptions

The following list of assumptions of SFBT is summarized from the following sources. Please refer to these authors for further reading on the assumptions of SFBT: Basile, 1996; Chevalier, 1995; DeJong & Berg, 1998; de Shazer, 1985, 1988; Lawson, 1994; O'Hanlon & Weiner-Davis, 1989; Walter & Peller, as cited in Coe & Zimpfer, 1996 and Sklare, 1997; Walter & Peller, 1996;

Reality is co-constructed. As discussed above, SFBT rests heavily on the assumption that our understanding of reality is a creation of our experiences. Language is viewed as creating meaning, or reality, rather than being an objective representation of reality. In SFBT, the therapist listens attentively to the client's use of language in describing the problem and then uses the client's exact phrases (Chevalier, 1995). Furthermore, the language used by the therapist is present- and future-oriented and assumes that change will occur. Solution-talk rather than problem-talk keeps the focus of sessions on what the client is doing that works.

The problem does not necessarily dictate the solution. It is not necessary to know in-depth details about the problem, or the cause of the problem, in order to resolve it. Thus, insight into the "root cause" of the problem is not necessary, and therapy focuses on observable actions. In fact, seeking the "cause" of the problem will likely impair the course of SFBT.

Change is constant and inevitable. Solution-focused therapy uses this phenomenon to its advantage by asking clients to take note of positive changes in their lives, no matter how small, and works with the client to build on these.

> The therapist's job is not to initiate change, but to punctuate the differences between the complaint pattern and the pattern of the exception (change) thereby making explicit the 'naturally' occurring variations which are in the direction of the desired solution. (Kral & Kowalski, 1989, p. 73)

Every problem has exceptions to it. No problem exists at all times. There are always times when the problem does not occur, and it is the therapist's duty to

help elicit these instances from the client. Thus, SFBT maintains a positive focus in concentrating on exceptions to the problem and encouraging clients to continue the actions that work.

Focusing on the positive helps empower the client and facilitates change. SFBT contains many of the same assumptions found in empowerment theory. Saleebey's strengths perspective version of empowerment theory (as cited in DeJong & Berg, 1998) holds the following assumptions, which are also intrinsic to the SFBT model:

1. Despite life's struggles, all persons possess strengths that can be marshaled to improve the quality of their lives. Practitioners should respect these strengths and the directions in which clients wish to apply themselves.
2. Client motivation is increased by a consistent emphasis on strengths as the client defines them.
3. Discovering strengths requires a process of cooperative exploration between clients and helpers; expert practitioners do not have the last word on what clients need to improve their lives.
4. Focusing on strengths turns practitioners away from the temptation to judge or blame clients for their difficulties and toward discovering how clients have managed to survive, even in the most difficult of circumstances.

5. All environments—even the most bleak—contain resources. (p.11)

Thus, SFBT assumes that focusing on the positive leads to quicker, more effective change, and the therapist attempts to direct the dialogue of the therapeutic interview in the direction of "solution talk" rather than "problem talk" (DeJong & Berg, 1998; O'Hanlon & Weiner-Davis, 1989).

Stone (1995) views empowerment within schools as resting on a foundation of: a) respect for the perceptions of the individual, b) validation of the individual, and c) a focus on success. All three areas are addressed by the theoretical assumptions of SFBT.

The client is competent. As mentioned above, it is believed that people have within themselves the ability to effect solutions in their lives, and all environments are viewed as possessing some resources. What a person's solutions are depends on what that individual's strengths and resources are.

The client is the expert. SFBT recognizes that there is no one right way to view things. The client's perspective of his/her own life is important, so practitioners pay special attention to the client's use of language and what the client wants. The client sets the goals of therapy, although the therapist may help the client to state goals in positive terms, meaning that the goal is stated in terms of observable differences rather than the absence of some behavior. Sklare (1997) refers to "the client as expert" assumption as the rule of: "If it ain't broke, don't fix it" (p. 8). In other words, the therapist should focus only on that which the

client perceives as the problem, not a personal agenda. The relationship is a collaborative one.

If what you are doing is not working, do something different. People tend to become stuck in the same patterns of interaction, despite evidence that the pattern is not working. Walter and Pellar (as cited in Sklare, 1997) provide an example of a person repeating ineffective strategies in the case of losing a wallet or a set of keys. The person may first look on the hallway table, and not finding it there, go to the kitchen counter. After looking in the kitchen, the person may then go to the bedroom, and then back to the hallway table, even though the person has already looked there. In counseling, when clients appear "resistant," this should be taken as a sign that the course of therapy is not working for them and that another course of action should be attempted.

One small change can lead to larger changes. In the literature, this is referred to as the "ripple effect" (e.g. Sklare, 1997). A small alteration in a person's behavior has a ripple effect throughout that person's social system. Other people adjust their responses in accordance to the new behavior, which is in turn met with more new behaviors on the individual's part.

SFBT in Schools: Further Presumed Advantages

Besides empowering clients, another advantage of SFBT seems to be the empowerment of counselors. As mentioned above, Mostert, Johnson, and Mostert (1997) and Downing and Harrison (1992) have discovered in their personal interactions with counselors that many of them expressed feelings that they were not adequately prepared for their job roles by their graduate counselor training

programs. In consulting with numerous school counselors over the years, Mostert and colleagues (1997) found that most felt overwhelmed and ineffective due to a number of conditions. "These factors appear to be internal to the school setting (e.g. heavy caseloads, inadequate resources, poor or nonexistent inservice training) and external (e.g. multiproblem families, the relative powerlessness of the students to effect significant change in their lives)" (p. 21). LaFountain (as cited in LaFountain & Garner, 1996) found similar perceptions when she surveyed school counselors and discovered that they felt "burned out when expected to perform duties in which they felt inadequately trained" (p. 131).

Based on the assumption that most school counselors use approaches associated with the problem-solving paradigm, LaFountain & Garner (1996) conducted a study to determine if the use of SFBT techniques by school counselors would affect their perceived "burnout." Using the Maslach Burnout Inventory for Educators as a pre- and post-measure of perceived burnout, the researchers found that school counselors who conducted solution-focused brief counseling groups had significantly more desirable scores on "Depersonalization" and "Personal Achievement" than those counselors who had also been trained in SFBT but had not adapted the model in their schools. However, these results were limited in that the counselors were able to choose whether or not to conduct SFBT groups rather than randomly assigned to experimental groups.

Other benefits of the model have been summarized by Ajmal and Rhodes (1995):

- The approach is very realistic, aiming to achieve small steps forward. It is "brief" specifically in the sense that it is very purposeful and aims to carry out the work as quickly as is reasonable. This does not imply a naïve belief that all difficult problems can be solved overnight, but rather that something constructive can usually be done, however modest.
- It will utilize the strengths of whatever style a particular teacher uses.
- Given its emphasis on understanding the client's worldview, style of thinking, problem conception, and a client's own goal, it tends to be culturally sensitive. This is intrinsic to the approach, not added later.
- Solution-focused thinking was developed by observing interactions and discourse, often between groups of people in difficult situations. This, we believe, has allowed it to be applicable in complex social situations such as school.
- It can easily be combined with specific techniques from other approaches. (pp. 20-21)

Hunter (as cited in Downing & Harrison, 1992) adds that a competency-based model that allows people to perceive their own strengths is directly linked to positive self-concept. The competency-based view of the model is also presumed to foster cooperation between school personnel, parents, and students; the present/future orientation drastically cuts down the length of time required for

counseling; and "the practical assumption that people will work for change only if they perceive a need to do so helps the busy counselor make effective choices about who to work with to maximize the opportunity and efficiency of change" (Murphy, 1994, p. 65).

Kral (1994) believes that the SFBT model is ideal for working with children for the following reasons: a) the model does not require insight on the part of clients, and children are developmentally limited in this capacity; b) the model does not require the client to know much language—rather, the counselor uses the client's level of language development and terminology in building solutions with the client; c) the model's use of positively-worded goals matches well with children's concrete cognitive style because it is easier for children to form a concrete image of a substitute behavior rather to imagine the absence of a behavior; d) the model is systemic and allows for many points of access within the school system; and e) children's lives are always changing, and the SFBT model uses this to its advantage.

As discussed above, LaFountain et al. (1996) view SFBT groups as overcoming many of the obstacles common to group work, such as time constraints, "lack of role models, labeling of participants, and misunderstanding of the group process by students and parents" (p. 257). The SFBT model views all problems and the process leading to their resolution as inherently similar. Thus, SFBT groups allow the counselor to help students with a variety of concerns within a single group. Since the group is heterogeneous in terms of the identified problem, the group is not labeled, such as an "anger management

group," or a "social skills group." School counselors who conduct individual counseling can direct children from their caseloads into such groups and, subsequently, free up time to serve more students. Children in counseling groups can also provide one another feedback and role models.

Research on SFBT

McKeel (1996) summarized the outcome and process research on SFBT and related issues and differentiated between the two types: "Outcome research evaluates the effectiveness of therapy. Typically, outcome studies summarize the results (outcome) of clients receiving treatment based on one model of therapy, or they compare the outcome of two or more treatment models" (p. 251), whereas "process studies often examine the immediate or long-term impact of a particular therapeutic intervention or strategy" (p. 254).

Outcome Research

Brevity. Early proponents of SFBT claimed the model to be the briefest of the brief models, often leading to client improvement after a single session (e.g. O'Hanlon & Wilk, as cited in Miller, 1994). However, the average number of sessions in SFBT has been reported to be about five sessions (de Shazer, as cited in McKeel, 1996), which seems to be the same average found across other models (Miller, 1994). The average range of sessions for a client across therapy models, brief or not, has been found to be four to eight sessions, with six being the mean (as discussed in McKeel, 1996). This mean includes cases in which clients terminated prematurely (e.g. quit after the first session). Such findings indicate that there really is no such thing as "brief" therapy—all therapy is brief—whether

by model design or by client choice. However, research is unclear whether clients who quit counseling after one or two sessions receive any benefit from the counseling.

Furthermore, McKeel (1996) summarized SFBT outcome studies on length of treatment to indicate an association between number of sessions and client improvement. This finding is congruent with research on other models that indicated peak success at eight sessions (Howard, Kopta, Krause, and Orlinsky, as cited in McKeel, 1996).

Efficacy. In the introduction to their book, Handbook of Psychotherapy and Behavior Change, 3rd Edition (1986), Garfield and Bergin comment on the theme of an "equal outcomes phenomenon" running through the research, and that "it is a somewhat startling experience to read accounts of dozens of studies comparing different treatments that found no differences in therapeutic outcomes" (p. 18).

The Brief Family Therapy Center has conducted two efficacy studies on SFBT and found client self-reported success rates of 72% in one and over 80% in the other (as cited in Lee, 1997). An unpublished Swedish outcome study of SFBT by Andreas (as cited in McKeel, 1996) reported 80% goal accomplishment in clients. These studies' findings are comparable to results from other comparative outcome studies looking at other models (Rhodes, 1993). However, studies such as these have been criticized for being nonempirical and relying solely on the self-perceptions of the client (e.g. Miller, 1994). McKeel sums up the outcome research as being promising, but inconclusive. Thus, SFBT may be

just as effective as other models, but more empirical research is necessary in this area.

SFBT in Schools. Outcome research on SFBT has also been conducted in the school setting, but with mixed results. For example, LaFountain, Garner, and Eliason (1996) conducted a study of solution-focused groups involving 57 counselors and 311 students in grades K-12. The researchers were interested in the efficacy of SFBT groups in the school setting, focusing on self-esteem, coping, locus of control, and goal attainment. Counselors were randomly assigned to either an experimental group or a wait-control group. Those in the experimental group were trained in SFBT and asked to select 4-8 children from their caseloads for the group. The Index of Personality Characteristics (IPC) was administered to all students as a pre- and post-measure because it provides some indication of the personal and social adjustment of children. Significant differences between the experimental and control groups were obtained on the IPC on some measures of self-esteem and coping, and counselor ratings indicated that 81% of the children achieved their individual goals to a moderate degree or higher. Limitations of this research were the lack of standardized parent- and teacher-reports, that subjects were hand-picked by the counselors, and the fact that many of the counselors were unable to complete the project.

Cook (1998) researched the effects of SFBT classroom guidance lessons on the self-concept of second graders, as measured by the Piers-Harris Self-Concept Scale (Piers, 1984). Cook randomly assigned four second grade classrooms to either an experimental group that received lessons on self-

confidence infused with SFBT techniques, or a control group, which received the self-confidence curriculum sans SFBT. Cook found no significant difference in self-concept between the groups at the end of the six-week units, nor did he find significant differences between pre- and post-intervention scores. However, qualitative analysis of student interviews revealed that some students in the experimental group experienced positive change.

Process Research

McKeel (1996) discusses some of the limitations of outcome studies as a) being too broad in scope—thus the finding that all therapies are generally equivalent in outcome, and b) not addressing the research questions most relevant to practicing therapists. Process studies of SFBT have taken a more pragmatic approach by looking at individual strategies and techniques to discover which aspects of therapy are most effective and which the client finds most useful.

McKeel (1996) summarized process research to evaluate claims made by SFBT proponents in the following areas: a) pretreatment change, b) presuppositional questions, c) the formula first session task, d) the therapeutic relationship, and e) solution talk.

Pretreatment change. Pretreatment change refers to the change that occurs between the client's initial contact with the therapist (usually the call to make an appointment) and the time of the first session. Many SFBT researchers have found significant pretreatment improvement in clients. McKeel summarized that pretreatment change occurred in 30-40% of SFBT clients.

Presuppositional questions. The language of many SFBT questions presupposes the answer. It is believed that this directs the client to look for positive change and personal strengths and resources. "These questions are interventions, designed so that the client will recall information that confirms the question's presupposition" (McKeel, 1996, p. 255). For example, the counselor might ask, "*When* the miracle happens, how will you be acting differently?" instead of "*If* the miracle happens..."

McKeel summarized research on a specific form of presuppositional questioning that asked clients to look for pretreatment change and summarized that roughly two-thirds of SFBT clients reported improvements before the first session. Conversely, McKeel and Weiner-Davis (as cited in McKeel, 1996) found that asking clients a question that presupposed that no change had occurred between the initial phone call and the first appointment resulted in 67% of the clients reporting no change. Thus, people appear to be highly suggestible in regards to their perceived benefit from counseling. However, whether such self-reports of positive change are indicative of actual therapeutic "success" remains unclear.

Formula first session task. The formula first session task is typically given to clients who need assistance in developing well-formed goals. This homework task is given after the first session and asks the client to notice what happens around them that they would like to continue to have happen.

McKeel (1996) summarized one exploratory study conducted at the Brief Family Therapy Center (BFTC). Therapists at BFTC asked 64% of 88 new

clients the formula first session task and found that 57% of these clients reported positive change occurring between the first and second session.

McKeel also mentions two well-designed process studies comparing the formula first session task and strategic/problem-focused methods. Jordan and Quinn (1994) compared treatment efficacy of the SFBT formula first session task and problem-focused brief family therapy in regards to a single goal identification session and found significant differences in terms of clients' perceived problem improvement, outcome expectancy, session depth, session smoothness, and how positively the client viewed the session. The other study, conducted by Adams, Piercy, and Jurich (as cited in McKeel, 1996), used client, therapist, and outside observer observation and concluded that the formula first session task led to increased client cooperation in that clients were significantly more likely to complete the formula task than the problem-focused homework. However, these researchers did not find that SFBT and the formula task increased client optimism, as Jordan and Quinn (1994) had.

Therapeutic relationship. The important role of a collaborative relationship between counselor and client has been well established in the literature (Corey & Corey, 1997; Yalom, 1995). McKeel (1996) states that many solution-oriented authors provide suggestions for enhancing client-therapist collaboration, yet these specific techniques have not been researched to date. McKeel suggests that research in this area will improve confidence in SFBT as a successful form of therapy.

Solution-talk. Solution talk is defined by McKeel (1996) as talk that focuses on and amplifies change:

> Examples of solution-talk include a therapist asking questions about change that occurred before treatment began, amplifying or reinforcing client improvement, identifying change that the client has ignored, and asking the client to brainstorm about action they can take to improve their situation. (p. 258)

McKeel cites two studies which have examined the relationship between solution-talk and therapeutic outcome: Gingerich, de Shazer, and Weiner-Davis (1988); and Shields, Sprenkle, and Constantine (1991). In the first study, Gingerich et al. studied therapy transcripts for evidence of client change in response to solution-talk by the therapist. The researchers discovered that client reports of change increased after the use of solution-talk. In the second study, Shields et al. found that the amount of client solution-talk in the first session was correlated with the client continuing treatment rather than terminating.

Since client outcome in therapy has been found to be affected by the quality of the client/therapist relationship no matter what the type of counseling, (Corey & Corey, 1997; Yalom, 1995), solution-talk in SFBT may lead to increased rapport between client and counselor. However, the association between solution-talk and the client's perceived quality of the counseling relationship has not been examined in research.

The SFBT Interview

The following section describes the common steps of the SFBT interview as conceptualized by DeJong & Berg (1998), including common questions and tasks employed in each step. Although DeJong & Berg's discussion focuses on interviews with individuals, the same solution-focused process and techniques apply to groups as well. Many SFBT techniques can be used with children, but some modifications are suggested where appropriate.

In SFBT, the interview itself is viewed as intervention in that clients often experience dramatic shifts in their perceptions after the first session, and "in many cases, a task assigned at the end of the session merely serves to reinforce the change which has already occurred" (O'Hanlon & Weiner-Davis, 1989, p. 78). According to DeJong & Miller (as cited in DeJong & Berg, 1998), the solution-building interview relies heavily on two activities: "The first is the development of well-formed goals within the client's frame of reference; the second is the development of solutions based upon exceptions" (p. 17).

Step 1: Problem Identification

The SFBT model recognizes the importance of a good therapeutic relationship between client and counselor (DeJong & Berg, 1998). Thus, after establishing some rapport with the client, the counselor attempts to elicit the reason(s) the client has come to counseling by asking a question such as, "How can I be of help to you?" In a school setting, most students are referred by either teachers or parents (Kral, 1994), in which case the student's perception of the referral would be explored. Normalizing statements—comments that lead the

client to perceive their difficulties as not so unusual—may be useful at this stage (Campbell, Elder, Gallagher, Simon, & Taylor, 1999).

The therapeutic relationship between the client and counselor generally falls into one of three categories: the customer-type relationship, the complainant-type relationship, and the visitor-type relationship (DeJong & Berg, 1998; De Shazer, 1988).

The customer-type relationship. In this relationship, the client demonstrates motivation in the therapeutic process by jointly working with the counselor to identify the problem, generate goals, describe exceptions, recognize strengths, and work toward solutions. This type of relationship usually develops with those clients who voluntarily seek counseling (DeJong & Berg, 1998).

The complainant-type relationship. The client in this relationship is able to work with the counselor at identifying the problem, is motivated to find a solution, but does not perceive him/herself as part of that solution. Commonly, the client expresses the desire that someone else needs to change for the problem to be resolved (DeJong & Berg, 1998).

The visitor-type relationship. In this relationship, the client and counselor are unable to identify a problem or establish a goal to work towards. This type of relationship usually stems from clients who are coerced or forced into counseling (e.g. most students) and often presents the most difficult cases to work with (DeJong & Berg, 1998).

The type of relationship the client and counselor have directs how the counselor proceeds with the session. For example, in a customer-type

relationship, the client is usually given a behavioral task at the end of the session; in a complainant-type relationship, the client is often given an observational task (de Shazer, 1988). However, that is not to say that the relationship does not change in the course of therapy. In fact, the solution-focused counselor attempts to shape complainant- and visitor-type relationships into customer-type relationships through the use of solution-focused questions and tasks.

As mentioned above, most children who see the counselor are not self-referred, and, thus, usually fall under the visitor-type relationship (Kral, 1994). After hearing the student's perceptions of the reason(s) for referral, the counselor may ask the student a question such as, "What will it take for you to get your teacher off your back?" (Kral, 1994). If the student and counselor can then generate some well-formed goals, the relationship becomes a customer-type.

According to Berg (1992), "many [SFBT] clients can be thought of as 'hidden' customers, that is, they may not initially be willing to deal with the very problem that got them referred to the program, but they may be willing to become a 'customer' for what they consider is important to them" (p. 30). Occasionally, the school counselor may have to deal with angry and hostile students who feel threatened by having to see the counselor. Berg (1992) offers several suggestions for handling such situations.

Kral (1994) cautions that school counselors need to be wary of who the actual client is, the person who "owns the problem." Sometimes the teacher, parent, administrator, or even the counselor is the actual client. However, actual clients do not have to perceive themselves as clients in order for the counselor to

be able to work with them. For example, the school counselor may ask a teacher to look for exceptions to a child's problem behavior in the classroom or describe what the child will act like when the problem is resolved. Thus, the child's behavior may be changed through working with that child's environment.

Negotiating realistic, solvable problems with the client is vital to a successful therapeutic outcome (Berg, 1992). In negotiating the problem(s), Berg (1992) suggests the counselor ask him/herself the following questions:

1. What is the referring person's view of what should be done with this family [or student, in the case of a school setting]?
2. What is the client's view of what should be done?
3. What is your view (or the team's, if you are part of a team)?
4. If there is someone else playing a key part (e.g. child protection worker), what does he or she think needs to change with this case? (p. 32)

Step 2: Developing Well-formed Goals

According to DeJong and Berg (1998), the counselor works to elicit from the client well-formed goals which are: a) important to the client; b) specific to place and setting; c) indicate the presence of some behavior rather than the absence; d) represent a beginning step rather than an end in themselves; e) are concrete, behavioral, and measurable; f) are realistic and achievable given the client's strengths and resources; g) are developed within the client's frame of reference; and h) imply personal control and responsibility.

One of the most popular solution-focused strategies for eliciting well-formed goals is the "miracle question" (DeJong & Berg, 1998; de Shazer, 1985; Kral, 1994). Kral (1994) credits the miracle question to Erickson's "crystal ball technique." DeShazer (1985) recommends the following version of the question:

> Now, I want to ask you a strange question. Suppose that while you are asleep tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However, because you are sleeping, you don't know the miracle has happened. So, when you wake up tomorrow morning, what will be different that will tell you that a miracle has happened and the problem which brought you here is solved? (p. 5)

A follow-up question such as the following may help further develop the goal: "What will you be doing when the problem is solved that lets you know it is solved?" Relationship questions—questions regarding the perceptions of significant others in the client's life—such as, "What would other kids in your class say you will be doing differently when the problem is solved?" or "How would your parent/teacher be able to tell the problem was solved?" are also an effective strategy to elicit well-formed goals. Finally, the repetitive use of "What else?" questions often leads to further elaboration by students (Sklare, 1997).

Younger children may have trouble with abstract concepts such as "miracle" and "goal" (Selekman, 1997). Since SFBT allows for the use of techniques from other types of therapy, play and art therapy strategies can be utilized with younger children to help them articulate their goals (Selekman,

1997). For instance, the counselor may have the child role-play or draw what things would look like after the problem was solved. Also, changing the language to fit the child's level of development may help. For example, the miracle question's wording could avoid the use of the term ""miracle" altogether and instead be phrased as a story in which a fairy godmother waves her magic wand and makes all the problems go away (Selekman, 1997).

When asked what their goals for counseling are, student responses generally fall into four categories: "a) positive goals, b) negative goals, c) harmful goals, and d) 'I don't know' goals" (Sklare, 1997, p. 20). Positive goals speak to the presence of some behavior, whereas negative goals are "expressed as the absence of something" (p. 21), and are nearly impossible to attain because they are hard to imagine. When goals are stated in a negative manner, the counselor asks the student what behaviors will be seen instead of the problem behavior. Thus, negative goals can be transformed into a well-formed goal.

Sometimes students may suggest goals that the counselor views as harmful to the student and/or others (e.g. dropping out of school, using drugs, hurting someone). In this situation, "counselors should recognize that student's destructive goals are really symptoms of underlying or root goals that reflect students' needs to fill voids in their lives" (Sklare, 1997, p. 25.) Through the use of solution-focused questions, the counselor delves deeper into the student's reasons behind the unhealthy goals until a productive objective is identified (Sklare). Thus, the counselor is still respectful of the student's expressed goals and approaches them with "a posture of not knowing" (DeJong & Berg, 1998, p.

63). Of course, some extreme instances may require that self-determination be taken away, such as with a high suicide risk.

Finally, Sklare (1997) mentions the "I don't know" goal as a favorite response of students. In this situation, he suggests the persistent repetition of "if" questions—"If you could guess...", "If you had some idea...", "If you did know..." (p. 27).

Step 3: Utilizing Exceptions

DeJong & Berg (1998) define exceptions as "those past experiences in a client's life when the problem might reasonably have been expected to occur but somehow did not" (p. 95). In this step, the client is encouraged to identify what has worked in the past and to do more of it in the future. The client may not immediately be able to recall exceptions to the problem, in which case the client would be assigned the homework task to notice instances when the problem might have occurred, but did not. Instead of focusing on the who, what, when, and where of the problem, the who, what, when, and where of the exceptions are sought out (DeJong & Miller, 1995).

Scaling questions are another strategy often employed in SFBT. They are advantageous in working with children because they help to establish the student's perceptions in concrete terms. In looking for exceptions, the counselor may ask the student to rate on a scale of 0 to 10, 10 being the miracle and 0 representing the worst occurrence of the problem, where the student perceives him/herself as experiencing the problem at present. No matter what number the student provides, the counselor can respond with an encouraging statement such

as "Wow! You're already at a two! What tells you that the miracle has already started to happen for you?" Even if the client states that they are at a zero, the counselor can remind the client of exceptions to the problem.

For younger children, more concrete methods of presenting the scale can be utilized, such as drawing a mountain--the peak representing the problem resolved--and asking the child to draw how far up the mountain he/she sees him/herself right now.

After it is established where the child presently perceives him/herself to be on the scale, the counselor asks the child to indicate where he/she would like to be-- the ideal goal. The counselor then focuses on helping the child envision small increments of change. For example, if the child perceives him/herself to be at a two, the counselor would ask the child to describe what a three would look like—"What will you be doing differently at three?" Nearly any aspect of the client's life can be scaled, such as motivation to attain the goal or confidence that the miracle will happen (DeJong & Berg, 1998).

Once an exception has been identified, Sklare (1997) advises that counselors help students mindmap how they were able to effect some of the miracle:

> *Mindmapping* refers to the creation of a road map of thoughts that guides individuals to their destination. Mindmaps are built by recalling and reinforcing instances when client's behaviors led to success, however small. This creates a sort of imprint of thoughts about what succeeds. Mindmapping seeks to reinforce thought

> patterns that will ultimately create what might be called productive habits—habitual ways of behaving successfully in areas that caused difficulty in the past. Recognizing their resources, responsibilities, and strengths is the first step in helping students feel empowered to take charge of themselves. (p. 47)

Sklare (1997) lists the following questions as helpful in creating mindmaps:

- "How did you manage to do that?"
- "What was different about this (or that) time?"
- "How do you account for these changes?"
- "That's so different. What brought that about in you?"
- "What kinds of different thought were you having then?"
- "How did you do it?" (p. 49)

Cheerleading is another strategy mentioned by Sklare (1997), where the counselor praises student successes through both verbal and nonverbal means. The counselor must be careful that the praise is genuine and not patronizing.

Step 4: End-of-Session Feedback

Feedback involves three parts: a) compliments, b) a bridge, and c) a task (DeJong & Berg, 1998). Compliments are "affirmations" (p. 109) of what the client is doing well in his/her life. Again, counselors need to be genuine in delivering their compliments to clients. The bridge links the compliments to the concluding task or remarks. "The content of the bridge is usually drawn from client goals, exceptions, strengths, or perceptions. Commonly, the practitioner will begin the bridging statement by saying, 'I agree with you that…' and ends

with 'Therefore, I suggest that...'" (DeJong & Berg, 1998, p. 110). Tasks fall into two main categories: observational tasks and behavioral tasks (de Shazer, 1988). An observational task instructs the client to pay attention to certain aspects of his/her life, whereas a behavioral task instructs the client to perform some action. As mentioned above, the counselor usually assigns a behavioral task to a client in a customer-type relationship and an observational task to a client in a complainant type-relationship. No task is assigned to the client in the visitor-type relationship (DeJong & Berg, 1998).

Step 5: Evaluating Client Progress

The previous stages are usually accomplished in a single longer session, or, in a school setting, over two or more shorter meetings. Once the objectives of the previous steps have been attained, the goal in subsequent sessions is "to open and sustain a dialogue around what's better for the client. In other words, the purpose is for the interviewer to engage the client in a search for exceptions that have occurred since the last time they met. These exceptions are the building blocks for a solution" (DeJong & Berg, 1998, p. 134).

Scaling questions are again useful at this stage because they provide a quantifiable, concrete representation of client progress. In the initial session, clients provide both a baseline number and a number representing the ideal goal. In each subsequent session, the counselor again asks the client to provide a numerical representation of how close he/she is to the ideal goal. Wherever the client falls on the scale, the counselor asks what it will take for the client to

advance one unit closer to the ideal goal. Thus, the counselor and client co-formulate short-term goals to reach the ideal goal (Sklare, 1997).

Another strategy at this stage is what Sklare (1997) calls, "flagging the minefield" (p. 54). The counselor and client collaboratively identify possible barriers to the client attaining his/her goals and what the client can do about them. Sklare advises that counselors use the following dialogue openers in discussing potential obstacles with students:

- "Your plan sounds great. However, we both know that sometimes, something or some people may get in the way of your accomplishing what you intend to do. How do you think that could happen in your situation?"
- "When that has happened in the past, what have you done that has worked to keep you on track?"
- "What do you think you can do to not let these things get in your way?" (p. 54)

After each session, the counselor assesses the client's desire to continue counseling. Counseling terminates when the client perceives his/her goals as being met.

Contraindications

As with any brief therapy, SFBT is limited in regards to certain client problems and conditions. Garfield (1998) contends that brief therapy should exclude "serious disorders such as psychoses, so-called borderline disorders, addictions, and the like" (p. 20). Corey and Corey (1997) believe "that group

work is contraindicated for individuals who are suicidal, extremely fragmented or acutely psychotic, sociopathic, facing extreme crisis, highly paranoid, or extremely self-centered" (p.113).

The proposed solution-focused groups will be homogeneous in terms of age, yet heterogeneous in regards to the problems each child will be finding solutions to. Yalom (1995) asserts that "there is considerable clinical consensus that patients are extremely poor candidates for a heterogeneous outpatient therapy group if they are brain-damaged, paranoid, hypochondriacal, addicted to drugs or alcohol, acutely psychotic, or sociopathic" (p.219).

Dennison (1997) adds that three behavioral patterns have been found in children to be contraindicative of group work. These are: psychotic behaviors, symptoms of paranoia, and narcissism.

Summary

Solution-focused therapy is beginning to emerge as an alternative form of therapy that may offer numerous benefits to school counselors at any level-- its efficiency and practicality; its positive focus on client strengths and resources; its respectfulness of individual differences and multiple perspectives; and its systemic nature. Initial research appears promising, but the model is so relatively new that few studies have evaluated its overall efficacy or its usefulness in regards to its use with children in schools. At present, the model appears to be at least as effective as other forms of therapy when used with adult populations, but more research is necessary to determine the model's effects on children. Furthermore, little research has examined the combination of SFBT and group

therapy, so this is also an area of needed study. Finally, despite findings that all therapies are "equal" in outcome, many proponents of SFBT still tout the model as possessing many advantages over traditional problem-solving models, but these assertions must be further explored.

CHAPTER 3

Method

Research Design

The current research was a qualitative exploratory case study of an upper elementary SFBT group composed of seven 4th, 5th, and 6th graders, referred to the group by school staff and/or parents for various behavioral, social, and/or emotional issues.

Pilot Group

A pilot group was conducted in the spring of 2002. The purpose of the pilot group was to provide a "trial run" of the group and the data collection surrounding it in order to identify potential difficulties so that these might be avoided during the actual group research. The pilot group also provided the researcher with some experience in using SFBT in a group setting.

The Researcher's Role

The SFBT groups were led by the researcher, who was a licensed school psychologist and school counselor with five years experience in the educational setting. The school was selected for study based on convenience and personal relevance—it was the researcher's place of employment. Leading a counseling group was considered part of the researcher's normal job activities, and the study was sanctioned by the district's superintendent, as well as the University of Montana's Institutional Review Board (approval was granted on 5-13-02).

The researcher first became acquainted with solution-focused therapy in a graduate course on Marriage and Family Counseling, and later gained experience

in solution-focused techniques under supervision from a clinical psychologist trained in such methods. The researcher also attended a workshop training on SFBT and read several books on the subject. Her interest in SFBT grew as children in individual counseling appeared to make rapid progress toward their goals and some positive feedback from parents was received.

Thus, the researcher's experiences with SFBT counseling prior to this study had been positive ones. Although an objective stance was strenuously attempted in all aspects of the study, her role as group leader and her past experiences with SFBT may have colored her perspective. However, as Yalom (1995) states:

> There is an art to obtaining patients' reports. Paper-and-pencil or sorting questionnaires provide easy data but often miss the nuances and the richness of the patients' experience. The more the questioner can enter into the experiential world of the patient, the more lucid and meaningful does the report of the therapy experience become. To the degree that the therapist is able to suppress personal bias, he or she becomes the ideal questioner: the therapist is trusted and, more than anyone else, understands the inner world of the patient. (p. 3)

Sample

Although Kral (1994) believes the SFBT model is ideal for working with children for the reasons discussed above, Selekman (1997) feels that younger children struggle with some of the abstract concepts involved, such as the terms

"miracle" and "goal." Taking both views into consideration, this study focused on older elementary students (grades 4, 5, and 6).

The SFBT group consisted of seven 4th, 5th, and 6th graders who were referred by school staff and/or parents for a variety of social, emotional, and/or behavioral difficulties. Most group referrals came from the K-4 school counselor's existing caseload and included children considered to have both "externalizing" and "internalizing" behavioral difficulties. Teachers tended to refer boys with outward behavioral problems in the classroom. Few referrals came from parents, and these also tended to be boys with visible behavioral difficulties.

The rural elementary school where the SFBT group took place consists of approximately 700 students (K-6) and shares a campus with the junior high. The female population at this school has remained generally 10% lower than the male population over the past three years, and ethnic/racial minority groups make up less than 5% of the student population. A quarter of the district's students are enrolled in the free and reduced lunch program.

Of the seven group participants, data from five were eventually analyzed, as one child was ill for several weeks and missed all but two groups, and the other child was receiving outside psychological services. The group's demographic makeup appeared to mirror that of the school's, as it was composed of four boys and three girls, all Caucasian. The children in the group ranged in age from 9 to 11. This fit with Dennison's (1997) suggestion that children's groups be composed of members within a two years' age range to ensure compatibility in

terms of cognitive, social, and emotional development. This also fits with Hayes and Oppenheim's (1997) view that people at similar cognitive levels share a similar structural perception of reality.

Each potential group member was screened for possible contraindications to brief group therapy using a modified version of Morganett's Tap-In Student Selection Checklist (1994, pp. 204-206; see Appendix A). This checklist was used to guide the screening/orientation interview prior to the group.

Treatment Experience

Group participants experienced six 45-minute sessions of SFBT, meeting once a week for six weeks, with the researcher flexibly following the SFBT group outline provided by LaFountain & Garner (1996; see Appendix B). Solution-focused questions, techniques, and tasks were implemented by the researcher where appropriate.

Procedures

Preparation and Recruitment Phase

The researcher advertised for a 4th, 5th, and 6th grade "Solution" Group in the fall of 2002 via e-mail to school staff, and a parent letter was sent home explaining the group and asking parents to contact the researcher if they felt the group might be beneficial to their child (see Appendix C). After two weeks of recruitment, the researcher had compiled a list of 33 potential group members. Most of these referrals came from the K-4th grade school counselor based on his caseload. Teacher referrals were less and in all instances were made for behavioral reasons. Only four referrals came from parents, three of these for

behavioral reasons and one for adjustment difficulties. Children known to the examiner to have Attention Deficit Hyperactivity Disorder were not included on the referral list. Unfortunately, this included two of the parent referrals.

Screening Phase

Prospective subjects were contacted by the researcher and given a permission slip/informed consent form to take home and have a parent or guardian sign (see Appendices D and E). Upon receipt of a signed permission slip, an individual intake/orientation interview was scheduled. Of the 33 permission slips sent home, ten were returned signed. Two of these were received past the designated deadline, after the group had already begun. Therefore, these two children were not considered.

Individual interviews with the other eight children were scheduled, and an assent form was provided to them at the beginning of the meeting (see Appendix F). All eight children eagerly signed this assent form.

Following suggestions from Smead (1995), Corey and Corey (1997), Morganett (1994), and Dennison (1997) on pre-group orientation meetings, the purposes of the intake interview for the children were:

- To explain the goals and nature of the group in detail.
- To identify what the child perceived as the problem.
- To go over the issues covered on the modified TAP-In Student Selection Checklist (Morganett, 1994, pp. 204-206; see Appendix A), including confidentiality, risks, ground rules, and meeting times/dates.
- To screen students for possible contraindications to joining the group.

- To answer any questions and address any concerns the student might have regarding the group.
- To make sure the student was not involved in any other counseling.
- To obtain student assent to the group and the study of it (see Appendix F).

At the end of this orientation interview, prospective group members were asked to sign the TAP-IN form as acknowledgement that all areas on the form had been discussed with them, their questions had been answered, and they understood the nature of the group and what was being asked of them.

Each child was then asked to fill out a form describing their problem and rate it on a scale from 1 to 10, one being the worst occurrence of the problem, and 10 being the problem completely resolved (see Appendix G). Students included in the group study were further asked to rate their problem at the beginning of every session using this form.

Subject Selection Phase

Subjects were selected for the group based on the following:

- Their score on the modified TAP-In Student Selection Checklist, from Morganett (1994, pp. 204-206; see Appendix A).
- No indication of thought disturbance or other difficulties contraindicating brief group work.
- No current involvement in outside counseling or regular involvement in another school-based counseling experience.
- Their assent to involvement in the study, as indicated by their signature on the Assent Form for Screening (see Appendix F).

- Parental informed consent (see Appendix E).

Only one of the children interviewed was determined not appropriate for group work. All students not admitted into the groups for any reason, including signed informed consent forms returned late, were referred to the school counselors for follow-up.

Pre-Group Measurement Phase

This study sought to better understand the effects of SFBT groups on children, and a subquestion pertaining to this was whether the SFBT group experience produced perceptions of desirable change in the children. To check for this, both quantitative broad-band and narrow-band measures were utilized.

Broad-band quantitative measures. Each subject's regular classroom teacher and a parent were asked to fill out Behavior Assessment Scale for Children (BASC) forms (Reynolds & Kamphaus, 1992) on the student—the teacher filled out the Teacher Rating Scale (TRS), and a parent filled out a Parent Rating Scale (PRS) prior to the first group. Each subject was also administered the Self-Report of Personality (SRP). The parent and teacher forms of the BASC each have three versions, depending on the age of the child. The preschool version is for ages 4 and 5, the child version is for ages 6 to 11, and the adolescent version is for ages 12 to 18. The self-report has two versions: the child version from age 8 to 11, and the adolescent version for ages 12 to 18. Given the age of subjects for this study, only the child versions of each form were used.

LaFountain and Garner (1994) reported one of their study's limitations to be instrumentation-- they felt they should have used more objective or behavioral

measures rather than solely relying on self-reports. This study seeks to employ more of a triangulating methodology, with parent, teacher and child each providing a cross-check on one another.

All BASC forms were computer-scored to obtain T-scores and percentiles in relation to the general norm population on a continuum of internalizing and externalizing behavior areas. (See Appendix H for a breakdown and discussion of the scales measured on the various BASC forms.) The BASC computer program provided graphs of resulting T-scores, statistical analysis of differences in scores, validity scale checks, a summary report of results, and interrater reliability coefficients for each subject. This computer program reduced the chances of human error in scoring.

The BASC Manual (Reynold & Kamphaus, 1992) includes standardization and norming information, as well as reliability and validity data, on the TRS, PRS, and SRP. The reader is referred to this source for a thorough discussion of each test's development. Reliability and validity data for the child versions of the TRS, PRS, and SRP is briefly summarized below.

Reliability data in the manual is reported in terms of internal consistency, test-retest reliability, and interrater reliability. High internal consistency is reported for the TRS, averaging .88 at ages 8 to11 for the general sample. For the PRS, internal consistency reliabilities averaged in the middle .80s to .90s. For the SRP, internal consistency was again reported as high, averaging .80 for both genders.

Test-retest reliability was also reported as quite good for the TRS, PRS, and SRP. The median correlation on the TRS was .91 when the same teacher rated the child again at a 2-8 week interval. When the same parent rated the child on the PRS again after 2-8 weeks, the median correlation was .88. Children demonstrated a median correlation of .76 when they rated themselves a second time several weeks later.

Interrater correlations between different teachers on the TRS were reported as moderately high, averaging .71. Parent agreement on the PRS was found to be moderate, averaging .57.

Finally, Reynold's and Kamphaus summarized data on how well the SRP, TRS, and PRS correlated with each other. Data collected from the BASC standardization demonstrated low to moderate correlations between teacher and parent that increased with the age of the child. The data also indicated that agreement was higher for externalizing problems, inattentiveness, and adaptive behaviors, presumably because these are easier to observe than internalizing behaviors. Furthermore, the SRP was found to correlate poorly with the adult reports, the highest correlation reaching about .4.

Although the BASC measurements did not demonstrate high correlations with one another, Reynold's and Kamphaus point out that the correlations are not any worse than those found by Achenbach (as cited in Reynolds & Kamphaus) in his meta-analyses of studies involving parent, teacher, and child reports of behavior. These differences are presumably due to differences in rater perspective.

Validity of the BASC was supported by its researchers examining: a) the factor structure of the scales; b) correlations of the BASC forms to other behavioral assessment devices; and c) score profiles of clinical samples.

Analysis of the factor structure of each BASC form indicated that slight adjustments be made to the original behavioral model on which the scales were based. The reader is referred to the manual for a complete discussion of the hypothetical models.

The TRS was correlated with five other instruments (the Behavior Rating Profile, Achenbach's Teacher Report Form, the Revised Behavior Problem Checklist, Connors' Teacher Rating Scales, and Burks' Behavior Rating Scales). Reynolds and Kamphaus (1992) summarized the correlational data as highly supportive of the construct validity of the externalizing and school-related problems scales.

Reynolds and Kamphaus (1992) summarize the correlational studies between the PRS and four other devices (the Child Behavior Checklist, the Personality Inventory for Children-Revised, the Connors' Parent Rating Scales, and the Behavior Rating Profile) as follows:

> High correlations were obtained with the CBCL and with externalizing scales of the CPRS-93, while correlations with the PIC-R and BRP scores were moderate. In general, as found for the BASC TRS, externalizing behaviors are measured more consistently across instruments than are internalizing or adaptive behaviors. p. 147

Previous correlational studies have examined the SRP with the following self-report instruments: the Minnesota Multiphasic Personality Inventory, Achenbach's Youth Self Report, the Behavior Rating Profile, and the Children's Personality Questionnaire. Reynold's and Kamphaus (1992) summarize that the SRP's Clinical Maladjustment Composite correlates well with the composites of the first three instruments, which are primarily problem-focused. The Children's Personality Questionnaire, however, is a measure of normal-range personality or temperament. Thus, the CPQ correlated only moderately with the SRP, the strongest correlation being between the SRP's Personal Adjustment Composite and the CPQ.

Finally, the validity of the BASC has been supported by research conducted on certain groups of children identified as having a clinical diagnosis independent of any BASC findings. BASC data has been collected on the following disability categories: conduct disorder/behavior disorder; depression; emotional disturbance; Attention Deficit Hyperactivity Disorder; learning disability; mild mental retardation; and autism (for the adult reports only). In sum, clinical profiles have been found to emerge which support the validity of the BASC instruments. The reader is again referred to the manual for a discussion of each profile.

Narrow-band quantitative measures. The SFBT group was composed of children working on a wide variety of different problems, all of them considered by the researcher to be "normal" childhood problems. Therefore, it was considered quite likely that a more clinical instrument like the BASC might not

pick up on behavioral change that was more specific to each child's presenting problem. To provide a more precise measure of behavior, each student's teacher was given a checklist that the teaching staff was familiar with as being part of the referral process to the school's Student Assistance Team. The checklist is aimed at identifying specific problem behaviors. The teachers were instructed to check all the problem behaviors that applied and then to provide a numerical rating beside the behaviors they marked on a scale from 0 to 10 -- 10 being the problem occurs all the time and to a great extreme, and 0 being the problem never occurs (see Appendix I).

Treatment Phase

The SFBT group was a closed group, meaning no student was allowed to join the group once it started. The group met once a week, for approximately 45 minutes, for a total of six weeks. The group flexibly followed the protocol of LaFountain and Garner (1994) as outlined in Appendix B, and a party with food and refreshments was held the last session. A variety of SFBT questions, techniques, and tasks were implemented. Additionally, the researcher made a note of each subject's personal goal during the orientation interview and asked each subject to provide a scale score for their progress toward that goal at that time and at the beginning of each group session. Finally, in the role of participant observer, the researcher took informal process notes each group.

Post-Group Phase

Teachers, parents, and subjects were asked to fill out their respective BASC forms two weeks after the group ended. Teachers were provided copies of

their initial informal checklists and ratings and asked to provide a second rating for each problem behavior they had checked prior to the group (see Appendix I). The reason for providing copies of the initial ratings stemmed from problems arising in the pilot study with teachers forgetting their originally identified concerns and ratings, resulting in a lack of correspondence between the pre- and post-measures.

As a subjective measure, the children were individually interviewed regarding their perceptions of the SFBT process (see Appendix J for the semi-structured interview protocol). Each interview was audiotaped and transcribed in a timely manner, and the audiotape was subsequently destroyed.

The gathered quantitative and qualitative data were then examined using an inductive process of analysis advocated by Stake (1997) and Cresswell (1997) involving: narrative description of the case, direct interpretation and categorical aggregation, searching for patterns, and making naturalistic generalizations.

The transcribed interviews were color-coded by the researcher for relevant themes, and the researcher's co-chairs provided a reliability check on these codings. One chair re-checked the researcher's previously coded transcripts and clearly agreed with the researcher's findings. The other chair independently coded the transcripts, resulting in generally good agreement (only 5 out of 57 codings not coinciding).

CHAPTER 4

Data Analysis and Results

The purpose of this study was to learn more about the effects of SFBT groups on elementary children with the hope of better understanding the therapy's potential usefulness for other elementary school counselors. Although not a generalizable study in the traditional sense, this research was an evaluation of the "successfulness" of this group in this particular instance--with these children, in this school setting, with this group leader, and with all the other contextual variables. According to Stake (1995):

> All evaluation studies are case studies...When fully in the role of program evaluator, the case study researcher chooses specific criteria or a set of interpretations by which the program's strengths and weaknesses, successes and failures, will become apparent. The more quantitative evaluator usually emphasizes productivity and effectiveness criteria, using measurements on a few outcome scales to make the case. The more qualitative evaluator usually emphasizes the quality of activities and processes, portraying them in narrative description and interpretive assertion. With all strategies, there is the essentiality of contexts, multiple points of view, and triangulation. The reader needs to understand the merit of the case—and the issues and criteria selected to make it happen. (pp. 95-96)

According to writers such as Bogdan and Biklen (1992) and Eisner (1991), the generalizability of a qualitative study depends on each reader's perception of the appropriateness of the findings for particular instances and circumstances. Therefore, it is important for the reader to be familiar with the study's context, the issues, and the criteria used to determine "success."

Therefore, a tentative list of criteria for a "successful group" was generated, based on the initial research questions. Each criterion would be considered met if the research question could be answered positively. These criteria were examined on two levels: the individual participant's subjective experiences (i.e. the microlevel) and the larger system outside of the immediate group (i.e. the macrolevel). Of course, the experiences of the individual participants made up the intermediate-level "group experience."

Of interest at the individual level were the following criteria:

- The group experience was perceived to be a positive one.
- Personal goals were considered attained.
- The child perceived positive change in behavior(s) associated with the problem and/or goal, pretreatment and/or overall.

By addressing each of these criteria for the individual child, it was believed some judgment could be made about the successfulness of the group as a whole.

Macrolevel analysis sought to discover if SFBT effects extended beyond the boundaries of the group. The following criteria were important at this level:

- The children able to generalize what they learned in the group to other problems.
- Self-perceived behavioral changes extended to behaviors not directly associated with the problem and/or goal.
- Parents and teachers perceived desirable behavioral change.

These criteria generated three main themes of interest: a) perceptions of a positive group experience, b) perceptions of positive behavioral change, and c) perceptions of empowerment and generalization.

To analyze the accumulated data in regards to the above criteria for a "successful group," Stake's (1995) four types of information analysis were employed: direct interpretation, categorical aggregation, looking for patterns, and naturalistic generalizations. In addition to these four methods, Cresswell (1998) suggests beginning with a detailed description of the case of interest. Therefore, analysis moved from narrative description of the group context, to an analysis of themes using direct interpretation and categorical aggregation, to interpretation and discussion of the themes.

Description of the Group

Out of the 33 permission slips sent home, ten were returned signed by a parent or guardian, and two of these were returned after the group had already begun.

Casual e-mails were sent to the five teachers of these students asking permission for each child to be excused from class for an orientation interview and asking for any times/days that would be the best to miss in terms of being the

least intrusive and educationally impactful. Two teachers e-mailed back that "anytime" would work for them. However, care was still taken to ensure that students were pulled from class at less intrusive times. By doing so, the teacher's response was, in every case, positive—the student would be cheerfully excused and provided instructions as to the assignment they were working on and where the class would be when the interview was finished.

Once at my office, the child was provided a quick verbal explanation of the group and an assent form for the child to read. In every case, the child eagerly signed assent, and the orientation interview continued. Of the eight orientation interviews, one child was screened out due to significant distractibility. This child had been referred to the group by his mother, via phone conversation. In questioning her about his current difficulties, it came to light that he had been diagnosed with Attention Deficit Hyperactivity Disorder, but that his mother felt this was under control and that he would function adequately in the group. However, the orientation experience demonstrated otherwise, as he had trouble maintaining eye contact for even brief amounts of time and kept asking for questions and responses to be repeated. He expressed a desire to be in the group and subsequently shared a problem he wanted to work on, but follow-up questioning drew him off-topic, and he began to talk about another problem, and then another. Thus, he was referred to his school counselor for one-on-one follow-up. He did not react negatively to the news that he would not be joining the group. This was framed for him not as a rejection, but as an opportunity for him to work individually with his counselor. In fact, he appeared pleased with

notion of receiving individual attention from the school counselor, with whom he had met before and had apparently established good rapport.

Upon going into the last orientation interview, six children had been identified as good candidates for the group, with room for two more children. Thus, when this last potential group member expressed that he was in outside counseling but still wanted to participate, it was decided to allow him in. Of course, his data was not included in the following analyses.

The group was scheduled to meet every Friday morning at 8:30 in the Shop room for approximately 45 minutes. This room was not considered the most conducive to counseling given its cold, industrial atmosphere and large size, but the space crunch at the school necessitated that the group take whatever room it could get. So, each morning, eight tall Shop stools were arranged in a small, intimate circle in the middle of the room.

The students in the group consisted of four boys and three girls between the ages of 9 and 11. Five were from 4th grade, one from 5th grade, and one from 6th grade. As is typical in a small school, the children came to the group with pre-existing relationships with other members, varying in their social connectedness and what they knew of each other. For example, two of the students in the group were cousins, and many of the children were friends outside the group. None of these students were in special education, and therefore, had never been evaluated by the leader in the role of school psychologist. All of these students were Caucasian, which was not unusual given the small percentage of minority students at this school.

The problems that these children brought to group were all, with one exception, of an interpersonal nature—they wanted to improve their relationships with people close to them. Two chose to work on improving a relationship with a stepparent, two with siblings, one with grandparents, and one with a peer. The other group member chose an academic goal of making the Honor Roll, but this child's data was not included in analysis for reasons already mentioned.

Group attendance, for most of the students, was judged to be good. However, one student did miss most of the groups due to illness, and the data gathered from this child is not included in the following analysis. As mentioned above, another student was involved with an outside counselor, and this child's data was also dropped from consideration. Thus, of the seven group participants, data from five were analyzed.

In the pilot group, the students rated their problems each session and then shared their ratings with the group. However, it soon became apparent that many children would change their ratings after hearing of the marvelous gains that another child had made since last group. The time spent sharing ratings seemed to become a competition among the members, each one in a race against the others up the rating scale. However, upon asking for an objective description of the rating from the child, the personal account would often contradict the numerical rating. For example, one girl rated her problem at a seven one session and objectively described a seven as fighting with her sister two times a week. The next session, she also rated the problem at a seven and stated that she was now fighting with her sister every day.

In an attempt to diminish social pressure to advance up the rating scale without the accompanying behavioral change in the second group, more emphasis was placed on honesty, and students were not allowed to openly share their ratings with the other members for the first three sessions.

Complete data were obtained for the five students described in the sections below. This included: participant observations; pre- and post-group BASC checklists from child, parent, and teacher; goal rating scale forms from each child; pre- and post-group informal behavior rating scales from the teachers for every student; and a transcribed, one-on-one, semi-structured exit interview. The first step in analyzing these data involved direct interpretation and categorical aggregation (Stake, 1995).

Direct Interpretation and Categorical Aggregation

According to Stake (1995):

> Two strategic ways that researchers reach new meanings about cases is through direct interpretation of the individual instance and through aggregation of instances until something can be said about them as a class. Case study relies on both of these methods. (p. 74)

Tabling of the data was found useful in facilitating the search for patterns and determining if the criteria for a successful group had been met. The process of "tabling" the data was an inductive procedure, moving from several individual tables with large amounts of discrete data towards one succinct table addressing the broad themes of "successful group" criteria.

These "successful group" criteria also provided a tentative list of categories by which to code text passages of the one-on-one exit interview transcripts. Thus, the transcripts were analyzed for evidence (and counter-evidence) of a positive group experience, perceptions of behavioral change, and feelings of empowerment or generalization of skills. Although these were the primary themes of interest, examination of the data was open to other interpretations. Each transcript was individually color-coded by underlining relevant quotes using a coding system developed by the researcher.

Did the Child Appear to Have a Positive Group Experience?

To determine if a child's group experience had been perceived as positive, the researcher noted attendance pattern, timeliness, comments about the experience made in the group, the exit interview transcript, secondary reports from teachers and parents, the general behavior and mood during group sessions, and whether the child terminated the group prematurely.

Did Positive Behavioral Change Occur?

The question of whether or not positive behavioral change occurred was examined in a myriad of ways by looking at the type of data, the informant, and the form of behavioral change (e.g. specific to the problem or broader, internal or interpersonal). The BASC reports and the teacher scale ratings pre- and post-group, as well as the children's scale ratings of goal attainment each group and exit interviews, were of importance here. Since each child articulated an interpersonal goal to work towards, the BASC scales of Interpersonal Relations, Social Stress, and Relations with Parents were of particular interest.

Table 1 below compiles data reflecting each child's perceptions of personal behavioral change, including any changes in individual scale ratings from pre-group to first session (i.e. Pre-Group Change in the table) and from pre-group to final session (i.e. Overall Rating Change in the table); whether or not the child stated in interview that the goal had been met; and whether BASC computer statistical analysis revealed significant positive or negative behavioral change from pre- to post-group at the .01, .05, or .10 alpha level of significance and on what scales (see Appendix H for a description of each BASC scale). In Table 1 and all subsequent tables, the children are identified by letter to protect their identities.

Table 1

Group Members' Perceptions of Behavioral Change and Goal Attainment

Students	**Pre-Group Change***	**Overall Rating Change***	**Significant BASC Change? (+ for positive change; - for negative change)**
A	2 to 3* (yes)	2 to 10 (yes)	+ for: Interpersonal Relations, Self-Esteem (.01 level)
B	2 to 3 (yes)	2 to 10 (yes)	No significant change
C	5 to 5 (no)	5 to 9 (yes)	+ for: Locus of Control, Depression, Relations w/ Parents (.01 level); Social Stress, Interpersonal Relations (.10 level)
D	5 to 5 (no)	5 to 10 (yes)	- for: Attitude to School (.05 level), Attitude to Teachers (.01 level)
E	1 to 2 (yes)	1 to 10 (yes)	+ for: Locus of Control, Social Stress, Depression (.01 level); Anxiety (.05 level); Sense of Inadequacy (.10 level)

*Initial rating and subsequent rating are provided, with a direct interpretation of whether the child perceived change. Thus, the entry of "2 to 3 (yes)" indicates that the rating changed from 2 to 3, so the child did perceive pretreatment change.

Table 2 below compiles behavioral data gathered from parent and teacher BASC reports on each child. Pre- and post-group correlational comparisons between the raters are provided; any individual scale T-scores that changed significantly from pre- to post-group at the .01 or .05 alpha level are listed; and individual scale T-scores on which the parent and teacher differed significantly at the .01 or .05 alpha level, either pre- or post-group, are also listed.

Table 2

Behavior Change from the BASC Perspective of Parents and Teachers

Student	Parent BASC	Teacher BASC	Teacher/Parent Correlations
A	No significant change	No significant change	Pre: 0.42 (No significant differences) Post: -0.06 (Parent more negative at .01 level for Withdrawal, Social Skills)
B	No significant change	No significant change	Pre: 0.31 (Teacher more negative at .01 level for Hyperactivity, Aggression) Post: 0.09 (Teacher more negative at .01 level for Aggression; .05 level for Hyperactivity)
C	No significant change	No significant change	Pre: -0.45 (Teacher more negative at .01 level for Hyperactivity, Aggression, Depression, Somatization; .05 level for Withdrawal, Social Skills) Post: -0.32 (Teacher more negative at .01 level for Social Skills, Leadership, Adaptive Skills, .05 for Somatization, Withdrawal, Adaptability)
D	No significant change	No significant change	Pre: 0.56 (Parent more negative at .01 level for Aggression, Depression) Post: 0.33 (Parent more negative at .01 level for Hyperactivity, Aggression, Depression, Attention Problems)
E	No significant change	No significant change	Pre: 0.40 (No significant differences) Post: 0.52 (No significant differences)

Data collected from the teachers' informal ratings taken pre- and post-group on each child include identification of problem behaviors and any qualitative difference in teacher ratings (see Table 3).

Table 3

Teacher's Informal Behavioral Problems Identification and Ratings

Student	Identified Problem(s)	Pre-Group Rating	Post-Group Rating	Desirable Change?
A	Short Attention Span	5	4	Yes
	Easily Distracted	5	3	Yes
	Often Off-Task	5	3	Yes
	Blurts Out Answers	3	2	Yes
	Rushes through Work	9	9	No
	Makes Careless Mistakes	9	9	No
	Trouble Keeping Hands, Feet, Objects to Self	4	2	Yes
	Often Leaves Seat	8	6	Yes
	Feels Picked On	7	2	Yes
	Tattles	3	1	Yes
	Easily Upset, Feelings Hurt	3	2	Yes
B	None	N/A	N/A	N/A
C	Short Attention Span	6	6	No
	Easily Distracted	8	5	Yes
	Often Off-Task	6	6	No
	Blurts Out Answers	8	6	Yes
	Makes Careless Mistakes	8	5	Yes
	Makes Inappropriate Comments	6	6	No
	Often Leaves Seat	8	8	No
	Few or No Friends	5	4	Yes
	Bossy	8	0	Yes
	Trouble Keeping Personal Boundaries	6	4	Yes
	Tattles	5	5	No
	Provokes or Agitates Others	6	6	No
	Verbally Aggressive	4	0	Yes
	Rebellious if Disciplined	8	6	Yes
	Shows Off	6	6	No
	Does Not Raise Hand	6	4	Yes

D	Daydreams	9	7	Yes
	Short Attention Span	9	7	Yes
	Easily Distracted	9	7	Yes
	Often Off-Task	9	7	Yes
	Squirms in Seat	6	3	Yes
	Rushes through Work	10	8	Yes
	Makes Careless Mistakes	9	7	Yes
	Trouble Keeping Hands, Feet, Objects to Self	6	3	Yes
	Often Leaves Seat	6	3	Yes
	Few or No Friends	7	5	Yes
	Unable to Work in Small Groups	5	4	Yes
	Provokes or Agitates Others	4	3	Yes
	Noncompliance with Directives	5	3	Yes
	Inappropriate Seat Behavior	5	3	Yes
	Looks Sad, Rarely Smiles	8	3	Yes
	Lacks Energy, Motivation	9	7	Yes
E	None	N/A	N/A	N/A

The teachers of students B and E expressed that they had no behavioral concerns regarding these children and maintained this view after the group ended. The other three children were identified as having behavioral difficulties prior to the group. For student A, 11 problem behaviors were identified, and 82% of these had improved post-group, ranging from 1 to 5 scale points, with an average change of 2 points. For student C, 14 behaviors were identified as problematic, and 64% of these improved, ranging from 1 to 8 scale points, with an average change of 3 points. Finally, for student D, 16 behaviors were identified, and all showed some amount of improvement, varying from 1 to 5 scale points of improvement with an average change of 2 points. None of the teachers reported negative behavioral change.

Was there Evidence to Suggest Generalizability or Empowerment?

Whether the children were able to generalize what they learned in the group to other problems, demonstrated broad behavior change, or were more empowered to solve their own problems outside of the group relates directly to benefits attributed to SFBT. Evidence was sought in the coded transcripts and in examining data from Tables 1, 2, and 3 above. Certain scales on the BASC self reports—specifically, the scales of Locus of Control, Sense of Inadequacy, and Self-Reliance—were of particular interest as indicative of empowerment, while significant change in behavioral scales not directly of an interpersonal nature was considered to point to more broad change.

Patterns

Through analysis of the data compiled in Tables 1, 2, and 3 above, as well as the coded interview transcripts, an attempt was made to answer each research question of interest on the individual, group, and systemic level. From the coded transcripts, a table was compiled to organize themes for each child. In Table 4 below, the researcher then made a direct interpretation of whether evidence existed in the interview to support the theme (entered as "yes" in the table), if there was evidence to the contrary (entered as "counter-evidence"), or if evidence of neither was apparent (entered as "no"). When evidence was mixed, both "yes" and "no" were entered.

Table 4

Analysis of Themes in the Coded Transcripts

Student	Positive Group Experience?	Positive Behavioral Change?	Internal Locus of Control (Empowerment)?	Generalizability To Other Problems?
A	Yes	Yes	No and Yes	No
B	Yes	Yes	No and Yes	Counter-evidence
C	Yes	Yes	No and Yes	No
D	Yes	Yes	No	Yes
E	Yes	Yes	Yes	No

Every child expressed that his/her goal had been achieved, that positive change occurred, and that the group was found useful. Three suggestions were offered for further groups: Student A suggested adding more children in order to offer "more ideas;" student B suggested being allowed to work on another problem after the first problem was solved, so that "it [the group] could be extra long;" and student C mentioned that he would have changed the inattentive behavior of two of the members. As other evidence indicated that the children experienced the group positively, these suggestions were not viewed as demonstrating an overall negative experience. For example, student C said that what he liked best about the group was "that you would be able to say what your problem was without being scared to say it or anything like that," indicating that a "safe" group environment was still perceived, despite some perceived negative behavior from a few group members.

Some of the children also alluded to some of the therapeutic factors identified by Yalom (1995) and Corey and Corey (1997). For example, when asked what was liked best about the group, student B responded, "You got to

know other kids. You got to help them out a bit," which relates to the therapeutic factor of Altruism (Yalom, 1995, p.12). Three children mentioned "advice from others" as being one of the most helpful aspects of the group (yet another of Yalom's factors—Imparting of Information, p. 8). Student B also stated that the group "helped me get along better with kids in the group that I didn't really know." This statement appears to point to feelings associated with Corey and Corey's factor of Caring and Acceptance (p. 248). Finally, the comment by student C, "that you would be able to say what your problem was without being scared to say it or anything like that," exemplifies what Corey and Corey (1997) refer to as the factors of Willingness to Risk (p. 247) and Trust and Self-Disclosure (p. 254). As these authors describe these factors as occurring in the "working stage" of a group, it would seem that the SFBT group was at least partially able to achieve this advanced level of group process.

Mixed evidence was found for feelings of empowerment in the interviews. As mentioned above, three children mentioned "advice from others" as being one of the most helpful aspects of the group, while students A and B presented as altogether uncertain as to how their goals had been met. In reference to the interpersonal problem changing, student B even stated, "for some reason, like two weeks into the group, he was really actually pretty nice to me and still is." Upon further questioning, student B guessed that maybe the change was due to the little brother "being a pain," but then hesitantly suggested that maybe it was because of personal maturation over the two weeks. Student A identified the impetus of change as the girlfriend of the boy "bullying" him, and that "when he [the

"bully"] was around her, he didn't bug me." Further questioning produced the opinion that the bullying behavior decreased as a result of student A ignoring the behavior, but it was revealed later in the interview that student A had also employed the help of another group member to tell on the "bully."

Given the degree of contradiction in the interviews regarding feelings of empowerment, the researcher turned to other types of data in determining if this criterion for a "successful group" had been met. Furthermore, as the interviews did not directly query the children regarding generalizability of their learned skills, little conclusion could be drawn from the transcripts in this regard. Again, other data were examined for evidence of generalization.

Data from Tables 1, 2, and 3 were integrated into a single table (see Table 5 below). In Table 5, a direct interpretation was made (i.e. a decision of "yes" or "no") as to whether each child met a criterion--from the perspective of child, parent, and teacher--based on the tabled data above and the coded transcripts. When a decision could not be reached based on contradictory or insufficient evidence, "mixed results" was entered in the table.

Table 5

Student by "Successful Group" Criteria

Student	Perspective	Positive Group Experience?	Positive Goal-Specific Behavioral Change?	Empowerment or Generalization?
A	Child	Yes	Yes	Mixed Evidence
	Parent		No	No
	Teacher		Yes	Yes
B	Child	Yes	Yes	Mixed Evidence
	Parent		No	No
	Teacher		No	Yes
C	Child	Yes	Yes	Mixed Evidence
	Parent		No	No
	Teacher		Yes	Yes
D	Child	Yes	Yes	Mixed Evidence
	Parent		No	No
	Teacher		Yes	Yes
E	Child	Yes	Yes	Mixed Evidence
	Parent		No	No
	Teacher		No	Yes

Did the Child Appear to Have a Positive Group Experience?

As mentioned above, it was believed that every child in the group had a positive experience, as evidenced by their observed enthusiasm for coming to the group, showing up on time, engagement in the activities presented, and positive interactions with other group members. None of the five students terminated prematurely. The students' exit interviews lent support to this assertion (see Table 4 above).

Did Positive Behavioral Change Occur?

The answer to this question appeared to vary according to rater and the method of data collection. However, in every case, the child reported attaining his or her goal on the scaling record form and in interview (see Table 1 above). Self-report BASCs indicated that three of the five children reported statistically significant positive change, of both an interpersonal nature (e.g. Interpersonal Relations, Relations with Parents, and/or Social Stress), and of a broader scope (e.g. Self-Esteem, Locus-Control, Depression, Anxiety, and/or Sense of Inadequacy).

Despite these positive findings, student B's BASCs reported no significant change, while student D reported statistically significant negative change. However, it must be mentioned that student B was reported by parent and teacher to be an extremely well-adjusted child with all scales within the average to better-than-average range both pre- and post-group. This child likewise presented in the group as socially mature, responsible, and "psychologically-minded." Therefore, it may not be surprising that statistically significant change was not reported as there was little room for growth.

Student D's negative behavioral change, on the other hand, was supported by the parent also reporting significant negative change. However, the behaviors that were perceived to worsen were not directly related to the child's goal. To complicate matters, this child's teacher perceived much behavioral improvement, both related to the problem and in a broader sense, according to informal ratings.

Three children did report pretreatment change. Interestingly, it appeared that this was more likely to occur the more negatively the child initially perceived the problem. The two children that did not initially rate their problem so terribly low (both at a 5) remained at the same rating when they began the group.

When teacher and parent BASC forms were compared to each other both pre- and post-group, similarity coefficients demonstrated a generally poor inter-rater agreement (see Table 2 above). Thus, parent and teacher appeared to perceive each child quite differently both before and after the group. However, such discrepancy in perspective was anticipated, given existing research on behavior checklist inter-rater agreement (e.g. Achenbach, 1987, and Earls, 1980, as cited in Reynolds & Kamphaus, 1992) and the constructivist underpinnings of this qualitative inquiry.

Despite such difference in views, parent and teacher BASC ratings did agree in not indicating statistically significant behavioral change pre- and post-group in all instances except one (the parent of student D, discussed above).

Table 3 (see above) indicated that the teachers who identified problem behaviors in group members perceived most of those behaviors to have improved by the end of the group. No post-group negative change for any problem behavior was reported.

In sum, to answer the question of whether positive behavioral change occurred, one must take a qualitative stance and add the qualifier, "from whose perspective?" In this case, parents did not generally perceive any change (at least not drastic enough to be considered "statistically significant"), the children did

perceive change, and the teachers saw some very specific positive changes, both directly relevant to the identified goal and peripheral.

Was there Evidence of Generalization or Empowerment?

As reported in the previous section, there was some evidence of broader change in three of the children's BASC self-reports. Besides significant changes on interpersonal scales, student A's self-report indicated significant change for Self-Esteem; student C's indicated improvement in Locus of Control and Depression; and student E's demonstrated improved Locus of Control, Depression, and Sense of Inadequacy. This evidence, along with the teachers' informal reports of broad classroom change, suggests that there was some generalization of behavior change and that some of the children experienced feelings of empowerment. However, evidence of empowerment and generalization in the student interviews was mixed.

Naturalistic Generalizations

In general, the SFBT group appeared to involve many of the same processes and therapeutic factors that any traditional counseling group would involve. In the context of a positive, supportive group atmosphere, the students were able to attain the stage of a "working group" within the six-session span. As the students came to this group with relationships among themselves already formed, rapport was already established in many cases, and perhaps this helped propel the group forward through the group stages at a more rapid rate. Although SFBT proponents would argue that change was probably accelerated by the

positive focus on student strengths, this positive focus was something the students did not articulate as helpful to them.

One benefit ascribed to the group by the students involved getting to know the other members better. One student expressed that she was able to drop her preconceived disdain of another boy in the group and found that he was actually "pretty cool." Another student learned that statements another student made in the group did not accurately reflect her observations of him outside of the group—she felt he was lying, but she was appreciative that she learned this about him.

Many students expressed that simply the act of talking about their problem helped them, but when pushed to explain how it was helpful, they often became confused and had trouble providing a reason. This is exemplified in the following fragment from student A's exit interview:

> **What did you like best about the group?**
>
> Talking about my problem.
>
> **Why did you like that?**
>
> Because I wanted to solve it.
>
> **How do you think talking about it helped to solve it?**
>
> Because…with other kids…people, well, D and C… well, not C, but D, saw what was going on and he helped me solve the problem.

Student A was referring to an incident outside the group in which Student D observed student A's conflict with a peer and told the teacher. Apparently,

student A felt his discussion of his problem in group made other students aware of it so that they might intervene outside the group.

Advice-asking and giving were favored techniques among the members and began to extend to times outside of the group. Two students even perceived the researcher as giving them advice when the researcher perceived this as "pointing out to them what they were already doing that worked and encouraging them to do more of it." This technique, however framed, was perceived as helpful. Student A even wished the group had been larger so that he might gather still more "ideas." This student perceived himself as having very little control over his peer interactions, attributed his problem to other children, and looked to others to solve this problem for him. When resolved, he attributed the problem resolution to another child. His view of his social world manifested itself in the classroom by his teacher perceiving him to feel picked on, become easily upset, and often tattle on peers. In group, he presented as very much "unempowered" and socially immature. However, despite all this, he still felt he accomplished his single interpersonal goal of preventing one boy from picking on him and asked if he could return for a future group.

In fact, every child perceived that his/her counseling goal was attained, and all, save one, perceived that they changed in ways both related to the goal and much broader. This is not unusual, given the 80% self-reported goal attainment rate found across other therapies (Garfield & Bergin, 1986). Furthermore, three of the children perceived such incredible behavioral change that their self-reports indicated statistically significant gains.

Parents and teachers generally demonstrated poor agreement in their observations of student behavior, both before the group and after the group. However, they did agree in their perceptions that such radical behavioral improvement in six weeks did not occur, as parents saw no significant change (and in one instance, negative change), while teachers reported much more mild qualitative changes.

Although the "equal outcomes phenomenon" of 80% goal attainment is considered by many as an objective measuring stick by which to gauge a group's successfulness, this self-report measure takes only the client's view into consideration and ignores the multiplicity of reality, the variability of perspective. When other views were considered in this study, however, it became less clear whether the children actually accomplished meaningful behavioral change or not. However, as parents were not provided the opportunity to provide qualitative ratings of problem behaviors as the teachers were, it is likely that the BASC checklists were too broad in scope to be sensitive to meaningful change—especially when the child is a generally well-adjusted one.

Another area of interest related to assertions made by many SFBT proponents that SFBT results in broad, systemic change and empowerment. However, it was unclear to the researcher whether the children were capable of transferring what they learned in the group to other problems or felt empowered to solve their own problems once the group ended. Although student B was considered by parent, teacher, and the researcher as very mature and well-

adjusted, her comments in her interview suggested that even she had no idea how the problem was solved, let alone her role as agent of change:

> **Tell me about the problem you decided to work on in the group and why you chose that problem.**
>
> I chose my brother fighting with me because we normally both get in trouble if I go tell. And, for some reason, like two weeks into the group, he was really actually pretty nice to me and still is.
>
> **So the problem changed as the group went on. Tell me more about that.**
>
> He always wants to do things with me. He's like…He's just changed.
>
> **How was he when the group first started?**
>
> He was always tickling me to make me mad.
>
> **Did *you* change at all over the course of the group?**
>
> Not really.
>
> **So, you don't know why he suddenly started acting differently?**
>
> No.
>
> **Could you take a guess?**
>
> Ummmm. [Several seconds of silence.] Because my little brother was being a pain?

Student B's comments later in this interview also point to her lack of generalizability to other problems, as she expresses regret that she had not chosen a more difficult problem to work on in the group:

> **So, do you feel you met your goal for the group?**
>
> Yeah. I could of, if I would of thinked a little harder about what my problem would have been, I could've had…My friend XXXX, she does not talk to me herself if it's something mean. She'll tell

my other best friend, XXXX, behind my back, and XXXX tells me on the bus.

So you wish you could have worked on another problem.

Yeah.

Do you think you could take some of the ideas you learned in group, like looking for times when the problem doesn't happen and doing more of what works, and using those things on this problem? Do you think you could do that yourself?

The one bad thing about that is I'd have to stop playing with all my friends because XXXX is the center of attention.

So you think it would be hard to use these ideas with that problem?

Yeah.

So you wish you had chosen that problem instead of the one you worked on.

Yeah.

Anything else that you would change?

We could do two problems. It could be extra long. If we solved a problem, then we could solve another one.

Like student A's suggestion of allowing more participants in the group in order to increase the amount of advice, student B's suggestion of allowing more problems to be discussed suggests reliance on others to help solve the problems.

Despite lack of evidence in the exit interviews, the children did report broad-based change in their behavioral checklists, and teachers also reported behavioral changes in the classroom that were seemingly unrelated to goal-specific interpersonal conflicts (such as reports of improved attentiveness and work habits). Given the cognitive level of development in these students, it is

likely that: 1) they were unable to insightfully recognize and/or articulate feelings of empowerment and/or generalizability in the interviews, and 2) they could not transfer their learning to new situations.

In sum, three broad criteria were examined in order to determine if the SFBT could be considered a "success:" a positive group experience, positive behavioral change, and generalization/empowerment. Of these three criteria, only the first could be considered as having been met with any degree of certainty, and this was perhaps because this was the only criterion that was not confounded by a multiplicity of different views. The second criterion could be considered as reached if the data gathered from the parents are discounted as too broad to be relevant and meaningful. Finally, data regarding empowerment were so mixed that no solid conclusion could be drawn, but there was evidence of broader systemic behavioral change in the children's BASC reports and in teachers' qualitative ratings.

CHAPTER 5

Discussion

Summary of Findings

Although initially described as a systemic, strengths-based mirror-image of strategic family therapy, solution-focused brief therapy (SFBT) has more recently expanded to the school setting and been re-conceptualized by its proponents as a postmodern model. As such, SFBT supporters attribute the approach with those benefits ascribed to the postmodern paradigm as a whole—particularly empowerment of the client and respect for multiple worldviews (e.g. DeJong & Berg, 1998). Earlier claims that SFBT was briefer and more successful than traditional problem-solving approaches have since been debunked, and claims to this have subsided (Miller, 1994). However, the claims of client empowerment and broad systemic change, as well as the notion that SFBT may be perceived as qualitatively different from traditional approaches, have all remained essentially unexamined. This has been particularly true of the use of SFBT in group-work and with children. Stake (1997) feels that a qualitative study can be significant if it can challenge assertions already accepted as naturalistic generalizations.

Therefore, this study's aim was to qualitatively explore the use of an SFBT group in an elementary school setting to try and elucidate some of the perceived effects of this model on the children involved. The research questions were conceptualized as reflecting three broad themes of perceived effect (positive group experience, positive behavioral change, and empowerment/generalization)

and on two levels (the individual microlevel and the broader systemic macrolevel). Thus, the questions of interest at the microlevel were:

- What were the general perceptions of children toward the SFBT group process? Do these perceptions support assertions made about SFBT producing empowerment?
- Was the SFBT group experience sensed to be a positive one?
- Were personal goals perceived to be attained?
- Did the child perceive positive change in behavior(s) associated with the problem and/or goal, pretreatment and/or overall?

By answering each of these questions for the individual child, it was believed some judgment could be made about the successfulness of the group as a whole.

The following research questions were important at the macrolevel:

- Were the children able to generalize what they learned in the group to other problems?
- Did any self-perceived behavioral changes extend to behaviors not directly associated with the problem and/or goal?
- Did parents and teachers perceive desirable behavioral change?

These questions came to act as organizing criteria in the inductive data analysis to determine this group's successfulness within its limited context. The findings reported in Chapter 4 will be briefly summarized here.

Did the Children Perceive the Group as a Positive Experience?

As a whole, the group experience was perceived to be a positive one. Every child reported meeting his/her individual goal, there was generally good attendance and punctuality, comments made in group were mostly positive towards the experience and one another, and there were no early terminations or expressed general displeasure either in the group or in exit interviews. The few direct comments made by parents and teachers were also positive.

Statements made in the exit interviews also pointed to therapeutic factors that are recognized to occur in the "working stage" of a group (Corey & Corey, 1997; Yalom, 1995), and this might also be taken as evidence of a positive group climate.

Was Positive Behavioral Change Perceived?

Every child reported goal attainment, and three children even perceived such change that their BASC self-reports indicated statistically significant improvement on scales considered directly related to the interpersonal problem and more indirect. Those children that viewed their problems as more problematic at intake were more likely to experience pretreatment change.

Although parents and teachers did not report statistically significant change on their BASCs, teachers still viewed qualitative behavioral improvement in those students initially seen as having classroom difficulties. Unfortunately, such qualitative ratings were not asked of parents.

Was there Evidence of Empowerment or Generalization?

In general, the children's exit interview transcripts did not support feelings of empowerment or the ability to transfer SFBT skills to other problems. Instead, the theme of advice-seeking and evidence of dependence on others were extracted. However, two of the children's BASC T-scores for Locus of Control were found to indicate more internalized locus of control post-group, at a statistically significant level. Thus, evidence of perceived empowerment was mixed.

Evidence of broader systemic change was found in the children's BASC self-reports and the teachers' qualitative ratings in that positive change was reported for behaviors not directly related to the identified goal.

Holistic Interpretations

Given the "equal outcomes" findings across counseling and psychotherapy models (Garfield & Bergin, 1986), it was assumed that the SFBT group would result in levels of goal attainment similar to other models. Although this was indeed found, this was not of primary interest or importance in this study. A large-scale quantitative meta-analysis would have been better suited to compare the therapeutic outcome of SFBT groups to other types of school counseling groups.

Of research interest were the claims that SFBT is different from traditional therapy models. As outcome research is viewed as too broad to catch subtle differences among therapies, process research is viewed as more meaningful in this regard (McKeel, 1996). In this study, the process of an SFBT group was

explored qualitatively. This study perhaps accentuated the model's similarities with the traditional paradigm (e.g. the goal attainment rate, the finding of common therapeutic factors), rather than supporting claims of difference (e.g. empowerment) and pointed to assertions made by Hubble, Duncan, and Miller (1999) regarding the existence of common successful therapeutic factors across mental health therapy models.

Hubble and colleagues (1999) cite Lambert in identifying and describing the "big four" common factors associated with successful therapy outcome: a) client/extratherapeutic factors; b) relationship factors; c) placebo, hope, and expectancy factors; and d) model/technique factors (pp 9-10). Client/extratherapuetic factors are those elements of the client and his/her life circumstances that the client brings into the therapy context. Relationship factors refer to the variables associated with the establishment and maintenance of a good working alliance between therapist and client. Placebo, hope, and expectancy are factors involving client and therapy perceptions towards therapy. Finally, the therapy model and the techniques involved narrowly constitute "beliefs and procedures unique to specific treatments" and, more broadly, as "healing rituals" (p. 10).

The mixed findings of this study in regards to empowerment cast some doubt on the broad assertions made by SFBT proponents, at least pertaining to children. Lyddon (1995) cites McWhirter's definition of empowerment as:

> ...the process by which people, organizations, or groups who are powerless (a) become aware of the power dynamics at work in

> their life context, (b) develop skills and capacities for gaining some reasonable control over their lives, (c) exercise this control without infringing on the rights of others, and (d) support the empowerment of others in their community. (p. 582)

The first point in this conceptualization of empowerment alludes to the need for insight. Although adults at Piaget's formal operations level of cognitive development may have the ability necessary for this insight, young children ages 7 to 11 are at Piaget's concrete operations level of cognition, and "they can reason only about the concrete, tangible things in their world: they are not yet able to reason about abstractions" (Berger, 1994, p.304). In sum, any assertions that SFBT produces empowerment in young children should be made with extreme caution as the definition of this term may not apply to children prior to the development of formal cognitive operations.

So, was the SFBT group successful or not? From the viewpoint of the children, it was. Even though evidence of empowerment or generalization was mixed, to have met this criterion would have been to "go above and beyond" what might normally be considered a successful group—particularly a group involving this age range.

Implications

Whose Perspective Counts the Most?

The variability in perspectives among parent, teacher, and child demonstrated in this study raises the question of whose perspective becomes most pertinent when the identified client is a child. Stake (1997) asserts that:

> Because they emphasize experiential and personal determination of knowledge, most qualitative researchers are relativists. With some philosophical underpinnings, their opponents interpret this to mean they consider all views, all interpretations, of equal value. Equality is an absolutist view, not a relativist view. Relativists believe the value of interpretations vary—relative to their credibility and utility. Every informant's personal reality is not equally important, either epistemologically or socially. Some interpretations are better than others. People have ways, not infallible but practical ways, of agreeing on which are the best explanations. (p. 102).

Stake advocates a rational constructivist view involving three levels of reality: 1) an objective reality that is essentially unknowable, 2) an "experiential reality," created from sensory input from reality #1, and 3) "rational reality," our socially pragmatic web of integrated interpretations (p. 100). Stake states:

> The appetizing view, certainly my view, is the nonparsimonous view that all three realities exist and have important effects on experience. The question of which reality to rely on, like the question of nature and nurture, is academic. It is self-jeopardizing to do other than keep #2 and #3 robust, and ignoring #1 is a poor way to cross a busy street. (p. 101)

Within a school system, Kral (1994) cautions that a counselor be aware of who the "real" client is when a child is referred. Thus, the client may not always be the child engaged in counseling, but may be a parent or teacher.

In other words, a school counselor must not only be aware of multiple and possibly conflicting perceptions of a child's behavior, but must determine which of these perceptions is the most credible in terms of goal attainment and reported behavior change. Unfortunately, little is known whether a child's (or even adult's) self-report of goal attainment means that significant others also perceive change (Prout & Prout, 1998). In a meta-analysis of 17 school counseling and psychotherapy studies conducted in a ten-year span, Prout and Prout (1998) found that self-report measures accounted for 69% of all outcome assessments, and the greatest treatment response was indicated on these self-reports. However, more overt measures of behavior, such as informant ratings and direct observations, pointed to much more modest change. "This raises the issue of the relationship between self-reports and behavioral change. It may be that the more internal changes generally reflected on self-report measures may not yield equally significant changes in overt behavior" (Prout & Prout, 1998, p. 132). Stake might interpret this as a poor correspondence between a child's reality and reality #1 and #3.

More Similar than Not

The realization that SFBT may be more similar to traditional therapy models than distinct has already gripped brief therapists such as Scott D. Miller (1994). In his article entitled, "The Solution Conspiracy: A Mystery in Three

Installments" (1994), Miller humorously likens his research into SFBT counselors' claims of difference to the Watergate scandal, and the mystery unfolds through his dialogue with "Brief-throat:"

> "The claims of difference made by the growing solution-focused/oriented crowd are unusually strong. As you have found out, however, the fact is that the evidence for these claims is exceptionally weak—if it exists at all."
>
> As Brief-throat paused to take a breath, I seized the opportunity to offer a counter-point, "Some might argue that, despite the lack of research, the experience of all of the therapists doing this style of therapy has to count for something."
>
> "Yes," Brief-throat responded, not missing a beat, "they may. But this only proves my point more."
>
> "And that point would be?" I asked, still uncertain of what I had heard.
>
> "That the major impact of solution-focused, solution-oriented models—or any therapy model for that matter—is on the therapist and not on their clients."
>
> Upon hearing Brief-throat state these points a second time, I was able to dispel the dissonance I had experienced. I had heard correctly. What's more, I also knew that Brief-throat's conclusions were right since my own research had, in fact, uncovered a few studies that actually showed, albeit indirectly, that

> the major impact of treatment models was on the therapist (Kaley, personal communication: Kolevzon, Green, Fortune, & Vosler, 1988). (pp. 31-32)

Future research may do well to forget trying to elucidate the differences among therapy models and simply focus on the similarities among them that produce desirable change. In fact, as mentioned above, such research has already begun to identify the common therapeutic factors involved in a successful counseling outcome (Yalom, 1995; Hubble et al., 1999), and Murphy (1999) has applied the discussion of these common factors to the school setting.

Further research might also focus more on the perceptions of the therapist, rather than the client. Specifically, it follows that a good fit between a counselor's personality style and the type of therapy model employed helps facilitate a favorable working alliance with the client and leads to greater counseling success. LaFountain (as cited in LaFountain & Garner, 1996) found some evidence to suggest that school counselors who chose to use SFBT techniques perceived less burn-out on the job, and this may be an area for further exploration.

Limitations

Because this inquiry was an exploratory case study of a single SFBT group with upper-elementary students from a single rural school, it is limited in its generalizability. However, broad generalizability is not a goal in qualitative research, as more positivistic approaches are better suited to this end. Rather, case study research can be valuable in modifying pre-existing grand

generalizations if interpretation of the case yields a counter-example (Stake, 1995). Alternatively, a case study can lend support to existing grand generalizations. Writers such as Bogdan and Biklen (1992) and Eisner (1991), place the responsibility of a qualitative study's generalizability on the reader; the generalizability of a qualitative study depends on each reader's perception of the appropriateness of the findings for particular instances. Thus, care was taken to provide the reader with adequate contextual information. However, some information was intentionally omitted or reported in aggregate form to protect the identities of the students involved.

The researcher acted as leader of the counseling group, gathered all data, and conducted the inductive analysis. The conclusions drawn from this research are the perceptions of the researcher, no doubt somewhat filtered and shaped by the researcher's background and biases, and others may interpret these findings differently. The researcher knowingly entered this study biased in favor of SFBT, but care was taken to set any presumed generalizations aside and examine the data in as neutral a manner as possible.

The cognitive level of development of the children in the group was found to be another limiting factor in that it seemed to have direct implications on the quality of "stories" and "rich detail" the children were able to provide in their exit interviews. For the most part, the children struggled to answer many of the open-ended interview questions, although these were felt to be worded at a developmentally appropriate level. In each interview, the researcher found herself adapting a closed style of questioning that the children more readily responded to,

but which evoked little qualitative information. Future research on the perceived effects of SFBT groups on children might approach the inquiry differently by perhaps videotaping group sessions and then analyzing the content for themes. Parents and children might also be interviewed for their perceptions of the process on the children. Because of the lack of qualitative depth extracted from the children's interviews, this inquiry may not be considered a true case study by some and was thus limited to the status of "exploratory study."

This study was further limited in that the parents were not asked to qualitatively describe their perception of their child's behaviors. It was rationalized that asking parents for yet more data might increase the likelihood of them not returning any of the forms. However, a vital source of information was missed. Again, future research might use parent (and teacher) interviews to supplement any quantitative data.

Finally, pre-existing relationships with the researcher and positive expectations regarding the effectiveness of the group may have affected how the children and staff rated behavioral change after the group, thereby reporting more positive change than actually occurred.

Questions for Further Inquiry

Some suggestions to improve the current research study were provided above. However, the value of further pursuit into children's perceptions of SFBT at this point in time is questionable, given their cognitive development level, their perceptions' seemingly poor correspondence with pragmatic reality, and given that all counseling models produce the same outcome. Before meaningful inquiry

can continue in this direction, it is recommended that the model's underlying postmodern philosophies be further clarified in regards to its applications with children. Even then, time and resources might be better spent in understanding the similarities among models that lead to change, rather than continuing to focus on differences that, in the end, matter little.

Stake (1997) identifies one of qualitative research's faults to be that "new puzzles are produced more frequently than solutions to old ones" (p. 45). Yet, Cresswell (1997) views this as one of qualitative inquiry's merits. Some of the "puzzles" produced by this study were:

- If a child with problematic behavior perceives counseling goal attainment, but the parents and teachers perceive no or limited changes, has counseling been successful? In other words, whose perspective is most important?
- Is the mechanism of postmodern counseling approaches with children different than with adults?
- What are the effects of SFBT (or the postmodern paradigm as a whole) on counselors? Do these effects accelerate therapeutic factors related to successful outcome?

In sum, this study found that the children perceived the SFBT group to be successful in helping them to solve their problems, but that the processes viewed as most helpful were therapeutic factors recognized across all therapy models—including the traditional problem-solving paradigm—as facilitative in producing change. Although some behavioral data pointed to broader behavioral change and

empowerment, the children's responses to interview questions did not reflect any insight into these processes. Thus, this study found that the structural process of facilitating change through group counseling seems to be the same no matter what the philosophical underpinnings of the model, at least in regards to young children. Because children's perceptions of the group counseling process might be the same no matter what the model employed, the most important factors in determining SFBT's usefulness for school counselors might be each individual counselor's context and his/her perceptions toward this model.

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APPENDIX A

Prescreening/Orientation Interview

Name of Student_____ Date_____

Age_____ Grade_____ Group Topic_____

Interviewer_____

The Interviewer TELLS:

- ❑ The name, purpose, and goals of the group.
- ❑ Where, when, and how often the group will meet.
- ❑ Who will be leading the group.

- ❑ The number of children who will be selected for the group. Not everyone who wants to be in the Solutions Group will be selected because there is limited space and this group is not the best choice for everyone. However, everyone who desires it will get to spend some time with the school counselor.

- ❑ In order to be in the group, you must give your verbal permission, and your parent (or guardian) must sign that you may be in the group.

- ❑ You will be asked to share some personal things about yourself, such as your feelings, ideas, behaviors, and opinions. However, no one will force you to share anything you don't want to. This is called the "Right to Pass" rule.

- ❑ It can be scary to be in a group because it can be frightening sharing things with others, but remember that you only need to share what you feel comfortable with.

- ❑ It could be very good for you to be in the group because you will learn how much power you really have over situations and problems, you might be able to provide some important suggestions to other children in the group, and you will be able to go through solving your problem with other children experiencing the same thing.

- ❑ In the group, we all agree to keep whatever is said by anybody in the group private. We call this the "confidentiality rule." That means that no one tells what anyone else says or does in the group. The other children will agree not to tell what you say or do in the group, and you must agree not to tell what they say or do in the group. Because we don't ever have control over what someone else does or says, we can't promise that someone might not tell what happens in group. I will be reminding everyone of the confidentiality rule throughout our group.

  Is there anything you want to ask about what I've said so far?

- ❑ There are some times when I need to share what you say with other adults, such as your parents. These times are:
  - If you say anything about harming yourself or someone else

- If you say anything about an adult hurting you or another child (in other words, child abuse)
- If the court (a judge) tells me I need to share the information

Is there anything you want to ask about this?

- ❑ All of the group members are expected to come on time for each meeting. We will work this out with you, your teacher, and your parents to make sure that you are free at the time of the group meetings. When the group starts, the members share things, and the group gets to be very important. So, if one person doesn't come, it affects everyone.

- ❑ You may miss some class instruction and/or some class work. However, it will be worked out with your teacher so that you are not penalized for missing class time.

- ❑ You have the right to quit the group at anytime. However, please let me know if you intend to stop coming to the group so that we can talk about your decision and some of the risks involved in dropping out of the group before it ends. If you decide to quit, the decision will not be held against you in any way.

- ❑ For everyone's safety, no one is allowed to physically hurt others in the group.

- ❑ In group, we sometimes practice new ways of doing things. Each group member is expected to do some practicing of new skills in group and sometimes outside of group, between meetings.

- ❑ Each person is expected to work on his/her own behavior and make changes.

- ❑ You will be expected to do some homework "tasks" and have them completed when due.

- ❑ You will be expected to fill out a behavior checklist before the group starts and again when the group ends. I will be there when you fill it out in case you have any questions about it. You will also be expected to have a brief talk with me after the group ends (exit interview), to discuss what you liked and did not like about the group, and how well you think it worked in helping you to solve your problem.

The Interviewer ASKS:

- ❑ Do you understand everything I've said about group so far?
- ❑ What else would you like to know about this group or the leader?
- ❑ Are you going to any other counselors or psychologists in a group or by yourself?

- ❑ If you are chosen for group, will you come to each meeting and come on time?
- ❑ Are you willing to share your feelings, ideas, and behaviors with the group?
- ❑ Are you willing to keep what other children say in the group confidential?
- ❑ Do you understand that there are some special times when I would have to share what you say in group with other adults, such as your parents?
- ❑ On a scale of 1 to 10, 1 meaning very little and 10 meaning a whole lot, how much do you want to be in the group?

NOTE: This completes the interview portion with the child. The next section is to be completed after the interview is finished.

For inclusion in the group, the following boxes must ALL be checked:

- ❑ Does the child seem to understand what the purpose and goals of the group are?
- ❑ Does the child appear to want to participate in and be a productive member of the group?
- ❑ Does the child seem to be making the decision to join the group independently or under the influence of others?
- ❑ Does the child appear to be giving assent?
- ❑ Does the child demonstrate any contraindications for brief group therapy (e.g. brain dysfunction such as low cognitive ability or ADHD; serious disorders such as psychoses; or appears to be suicidal, extremely fragmented or acutely psychotic, sociopathic, facing extreme crisis, highly paranoid, hypochondriacal, or extremely self-centered). In instances of contraindications of group work, referral will be made to the school counselor for follow-up with more appropriate services.

Other Considerations:

- ❑ Does the child have some positive behaviors/attitudes that would serve as a model for some of the other potential members?
- ❑ Does the child seem compatible with other group members tentatively selected?

❑ **SELECTED**

❑ **NOT SELECTED**

Jennifer Demmons School Psychologist	Date	Student Signature*	Date

*Student signature acknowledges understanding and assent of the above rules and conditions.

APPENDIX B

SFBT Group Sessions Outline (LaFountain & Garner, 1996)

I. Session 1: Forming

A. Objectives

1. For students to get acquainted in the group and with group rules and procedures

2. To set the tone for interaction through a group activity

3. For students to share what they want to change in their lives

B. Procedure and counselor strategies

1. Students introduce themselves and establish ground rules

2. Counselor conducts an activity that promotes interaction and getting to know one another.

3. Students share what they want to change in their lives.

a. Counselor listens for each student's

1) Belief about the situation

2) Use of language

3) Use of absolutes and labels

4) Presentation of any exceptions

5) Potential goal

b. Counselor reflects back less disturbed language to the student (e.g., use of *discouraged* instead of *depressed*).

c. Counselor replaces absolutes with qualifiers.

d. Counselor asks for exceptions when student speaks of absolutes.

4. Counselor ends the group by offering encouragement to the members and by saying, "This week notice what happens to you that you want to continue to happen."

II. Session 2: Establishing Goals

A. Objective: Students will begin to establish a process goal

B. Procedure and counselor strategies

1. Review of homework

a. Counselor asks the group, "What happened this last week that you'd like to see more of?"

1) To those that identify changes, the counselor asks some of the following:

a) "What did you do to get that to happen?"

b) "How did you get that to happen?"

c) "What did you do differently?" (Walter & Pellar, 1992)

2) To those who do not identify changes, the counselor asks the following:

a) "Remind us of what changes you wanted to happen."

b) "Tell us about a time when it happened a little bit."

c) "If you changed the place, etc., would it help?"

2. Goal setting is introduced

a. Counselor presents the following hypothetical situation to the group: "Suppose that tonight while you are asleep there is a

miracle and the problem is solved. How would you know? What would you be doing differently?" (de Shazer, 1988, p. 5) Students share their responses.

b. A realistic goal. The counselor states the following: "Now that we have an idea of what you would like to be different and since miracles aren't likely, tell us what *you will be doing* to get that to happen." Students share their responses.

c. Counselor encourages the group.

d. Counselor directs the students to come up with a goal for next week. The goal is to begin with, "I will be..."

III. Session 3: Keys to solutions

A. Objective: To help students identify solutions (keys to solving their problems)

B. Procedures and counselor strategies

1. Students share their process goals. Counselor silently assesses the students' goals according to the criteria of a process goal and, when necessary, helps students to restate their individual goals to meet the criteria. The criteria are:

a. Positive presentation

b. In process form: "I will be..."

c. In the here and now

d. Specific

e. Within student's control

f. In the student's language

2. Counselor presents a skeleton key and asks the students what skeleton keys are used for. (Counselor elicits that one skeleton key can fit many locks.)

3. Counselor explains various keys: exceptions, doing something differently, pretending, and so forth, and points out some keys that students are already using (while handing out a replica of a skeleton key to the student as each key is identified.)

4. Counselor encourages group members to point out keys that they notice each other using (while continuing to hand out keys).

5. Counselor directs the students to look for the skeleton key (solutions) that they use toward their goal.

IV. Session 4: Progress toward goals

A. Objectives

1. Students will share their progress toward their goals.

2. Students who are stuck will ask for assistance.

B. Procedures and counselor strategies

1. Counselor asks the students what an obstacle course is.

2. As students share their progress toward their goal, the counselor compares their progress to an obstacle course.

3. Counselor processes the exercise by assessing the students' obstacles (de Shazer & Molnar, 1984) and saying

a. To those who are progressing (those jumping the hurdles), "Continue to do more of what you are already doing."

b. To those who are stuck (those stuck in the mud), "Between now and the next time, I want you to observe in your life what you want to continue."

c. To those who have used up all of their options (those caught in a rut), "Do something different."

d. To those who are having difficulty controlling themselves (those tripping, running haphazardly), "Before we meet again, pay attention to what you do to overcome the temptation or urge."

4. Counselor encourages the group.

5. Counselor has the group members review their individual directives for the week.

V. Subsequent session

A. Objectives

1. To help students maintain progress towards their goals

2. Students who are stuck will ask for assistance

B. Procedures and counselor strategies: Counselors develop subsequent sessions around the needs of the group.

VI. Termination session

A. Objectives

1. To help students review the skills they have learned

2. To help students continue the progress they are making

3. To celebrate change

B. Procedure and counselor strategies

1. Counselor asks students to share their progress as it relates to their goal.

2. Counselor encourages members to share feedback.

3. Counselor asks the students to tell what they have learned in the group and has them speak of the possible obstacles they will face in the future.

4. Counselor encourages students on their changes and promotes their serving as a support system to each other in the future.

5. Session is ended with refreshments or a party.

APPENDIX C
Notice to Parents

Dear Parent/Guardian:

Frenchtown Elementary is offering solution-focused counseling groups this spring for selected 4th, 5th, and 6th grade students who have been referred by parent(s), school staff, or themselves for any kind of social, behavioral, or emotional difficulty. All referred students must go through an interview process before being selected for the group, and no student may participate without signed permission from a parent or guardian. There is room in the group for a maximum of eight students. Therefore, you are encouraged to refer your child to Jennifer Demmons as soon as possible. Any referred student not selected for the group will be referred to his/her school counselor.

What is Solution-Focused Counseling?
Solution-focused counseling emphasizes and builds on each child's strengths rather than what the child is doing wrong. It is believed that by focusing on what the child is already doing that works (and getting the child to do more of it), problem behaviors will naturally decrease, and children will feel more empowered toward solving their own problems after the group ends.

Who is leading the group?
The group will be lead by the district psychologist, Jennifer Demmons. Mrs. Demmons has an M.A. in mental health counseling and an M.A. and Ed.S. in school psychology. She is currently pursuing her doctorate at the U of M and will be conducting research on how well solution-focused group counseling works with upper-elementary students. Therefore, if your child were referred to participate, you and your child's teacher would be asked to fill out behavior checklists on your child before and after the group. Your child would also be asked to fill out checklists and partake in an exit interview after the last group.

Confidentiality
Although results of the research project will be reported in Mrs. Demmons' dissertation, no subject will be identified by name or other identifying information in order to protect confidentiality.

When, Where, How Long?
The group will begin this spring and meet twice a week for three weeks. Each session will take place at school during your child's regular school day at a time that is mutually agreed upon by school staff.

Further Information
If you would like further information and/or would like to refer your child for the group, please call Jennifer Demmons at 626-4414.

APPENDIX D

Cover Letter for Parental Informed Consent Form

Dear Parent/Guardian:

Your child has been referred as possibly benefiting from the "Solution" group being offered this spring. If you did not receive the school letter pertaining to this group, this has been attached.

Also attached is a parental consent form that provides further information on the screening process, what the group entails, and what research will be conducted. Please read this consent form carefully, and if you have further questions, please feel free to contact me at 626-4414.

If you consent to your child's involvement in this process, please return the consent form to school with your child by_____.

Sincerely,

Jennifer Demmons
School Psychologist

APPENDIX E
Parental Informed Consent Form

Title of Proposed Study: An Exploratory Study of the Usefulness of Solution-Focused Brief Therapy Groups with Elementary Children

Jennifer Demmons
Researcher
Department of Counseling, School of Education
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Missoula, MT 59812
Telephone (626-4414)

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Dr. George Camp
Research Supervisor
Dept. of School Psychology, School of Psychology
The University of Montana
Missoula, MT 59812
Telephone (243- 4731)

This consent form may contain words that are new to you. If you read anything that is not clear to you, please call Jennifer Demmons at 626-4414 for an explanation.

Purpose

Solution-focused counseling emphasizes and builds on each child's strengths rather than what the child is doing wrong. It is believed that by focusing on what the child is already doing that works (and getting the child to do more of it), problem behaviors will naturally decrease, and children will feel more empowered toward solving their own problems after the group ends. Initial research on this form of counseling seems very promising, but more is needed.

The goals of the solution-focused group are:

- To offer children a safe environment in which to express their feelings and opinions, and in which to receive help and support from other children,
- To increase children's feelings of empowerment by allowing children to identify their existing strengths and build on these,
- To help children find workable solutions to their problems.

Your child has been referred as possibly benefiting from this group. Thus, your child is being asked to participate in this research study that will look at your child's behavior before the group and again after the group to see if there was any beneficial change which might, in part, be attributed to the counseling group. Your child's perceptions of the group process will also be examined to see if some counseling techniques were viewed as more beneficial than others.

Procedures

If you agree to have your child take part in the counseling group and the research project, your child will meet with me for an orientation interview, at which time your child will learn more about the group, can decide if he/she would like to join the group, and will have the opportunity to ask questions. At the same time, I can determine whether joining this group is appropriate for your child. Every child is different, and group counseling is not the best choice for everyone. If group counseling is not a good choice for your child, other counseling services will be made available to him/her. In the event that your child appears to be a good

candidate for the group, but the group is already filled with eight children, another counseling group with his/her school counselor will be made available to him/her.

Furthermore, if you agree to have your child participate, you, your child, and your child's homeroom teacher will be asked to complete a behavioral checklist before the group starts and again after the group ends. These surveys take about 20 minutes each to complete. Your child will also be asked to meet with me after the group ends for an exit interview to learn more about what your child thought about the group. This interview will be audiotaped, transcribed, and then the tape destroyed.

The group will meet twice a week for three weeks. Each session will take place at school during your child's regular school day at a time that is mutually agreed upon by school staff.

Once the study ends and the research report is written, the results will be made available to you at the Frenchtown Elementary Library.

Voluntary Participation/Withdrawal

You and your child's decision to take part in the group and research is entirely voluntary. You may refuse to have you or your child participate, or you may choose to have your child withdraw at anytime. Your child also has this option. If your child does not wish to participate or withdraws from the study, he/she does so without penalty.

Potential Risks

As this is a positive, strengths-based approach to counseling, minimal risk is expected. However, there are risks in regards to the limits of confidentiality. First of all, it cannot be guaranteed that children in the group will keep each other's confidences. Secondly, there is a slight risk that a subject may choose to disclose personal information that is unfitting for the group, or felt to be embarrassing by the subject's family.

Furthermore, subjects may disclose more information than they feel comfortable with and then later regret it. Another potential risk involves dropping out of the group prematurely, possibly leading to the child feeling worse about the problem. Finally, children who undergo the screening interview but are not good candidates for a school counseling group may feel badly about not being chosen.

Minimizing Risks

The above potential risks will be minimized as much as possible. The limits of confidentiality will be discussed with prospective subjects during the orientation interview and are outlined below. The importance of keeping confidentiality will

be stressed to subjects during the screening interview and repeatedly during group sessions.

In the event that a subject should begin disclosing information that is deemed too serious in nature for the group, the subject will be quickly redirected by the researcher and talked with privately after the session to find out how the subject is feeling about the disclosure and if confidentiality needs to be broken by the researcher (in other words, if parents or others need to be contacted).

In the event that the child begins to disclose information that is deemed to be simply embarrassing and off-topic by the researcher, the subject will be redirected.

Children who wish to voluntarily withdraw from the group may do so at anytime. However, to minimize the risk associated with this, children are asked to meet with the researcher once this choice is made to make certain the child is comfortable with this decision.

To help ensure that subjects do not feel pressured to share more than they feel comfortable with, the "right to pass" rule will be explained at the screening interview and intermittently during group sessions. Subjects will also be told at the screening interview and reminded throughout the group to share only as much as they feel comfortable with.

Finally, of those children who cannot participate in a group due to various reasons, they will be provided alternative school-related activities. For example, they might be invited to go down to the counselor's office with a friend of their choice to play a game.

Benefits

Proponents of solution-focused counseling feel it has numerous benefits over most other forms of school counseling. In short, it is believed to be: just as effective as long-term therapy approaches in effecting positive change in as few as one session; less stigmatizing of clients because it focuses on client strengths and "what works;" more respectful of individual differences; more efficient for school counselors and psychologists; more empowering because it teaches children how to solve their own problems; and more fostering of cooperation between school personnel and families.

Initial research appears very promising, but more is needed to help validate this approach. If this group appears to work well with children, more solution-focused groups might be offered at Frenchtown School in the future.

Confidentiality

Although I can assure you that what your child says in the group will be kept confidential by myself, I cannot guarantee that other children in the group will not break confidentiality. This will be discussed with the children during the orientation interview and during group sessions, and the importance of confidentiality will be stressed.

There are certain legal limits to confidentiality. I am bound by law and ethics to break confidentiality under the following conditions:

- A child intends to physically hurt another person or him/herself.
- A child reports being abused/neglected.
- A court orders me to break confidentiality with a subpoena.

In the event that direct quotes or behavioral data from subjects will be used in the research paper, subjects will be identified with a letter system, and the "key" will be kept in a locked file cabinet, stored separately from the other collected data. Only the researcher has access to this information.

The audiotaped interviews will be promptly transcribed by the researcher without any identifying information, and then the tapes destroyed. In the interim, they will also be stored in the locked file cabinet with the other data.

Compensation for Injury

Although only minimal risk is believed to be associated with involvement in this study, the following liability statement is required in all University of Montana consent forms:

"In the event that you are injured as a result of this research, you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitles to reimbursement or compensation pursuant to the Comprehensive State Plan established by the Department of the Administration under the authority of M.C.A., Title 2, chapter 9. In the event of a claim of such injury, further information may be obtained from the University's Claims representative or University Legal Counsel. (Reviewed by University Legal Counsel, July 6, 1993)"

Questions

If you have any questions about the group or research now or during the group, please contact Jennifer Demmons at 626-4414. If you have any questions regarding your child's rights as a research subject, you may contact Dr. Rudbach through the Research Office at the University of Montana at 243-6670.

Parental Statement of Consent

I have read the attached description of the counseling group and research study. I have been informed of the potential benefits and possible risks involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by the researcher (Jennifer Demmons). I voluntarily agree to have my child take part in this study. I understand that I will receive a copy of this assent form.

_____ _____

Parent Signature Date

APPENDIX F

Assent Form for Screening

Frenchtown School is going to have a counseling group soon for some 4th, 5th, and 6th graders. The group is called a "Solutions" group because students in it will be trying to figure out solutions for problems that they want to solve. The problems could be such things as: having a hard time making and keeping friends, getting in too much trouble at school, getting poor grades... or something else. You could learn how to solve a problem while you help other kids solve theirs.

Students who join the group will also be asked to share their thoughts and feelings about the problem, fill out some checklists, and talk with Mrs. Demmons after the group ends about what they thought about the group. No one will be asked to share more than he or she feels comfortable with.

Mrs. Demmons will be leading the group, and she will be meeting with students before the group starts to talk more about what the group is all about. No one will be forced to meet with Mrs. Demmons or join the group if he/she chooses not to, and a student could drop out at anytime without any problems. If you agree to meeting with Mrs. Demmons and possibly joining the group, please sign your name below.

I have read this paper and understand what I'm being asked to do. I would like to meet with Mrs. Demmons to talk more about possibly joining the group. I understand that if I have any questions about the group now or in the future, I can ask Mrs. Demmons at any time.

_____ _____

Student Signature Date

APPENDIX G

Forms Used in Group

The problem I am working on is:______________________________________

____.

My goal looks like: ____

____.

Today's Date:________ Today, I am at a:

1	2	3	4	5	6	7	8	9	10
Problem At Worst									Problem at Best

Today's Date:________ Today, I am at a:

1	2	3	4	5	6	7	8	9	10
Problem At Worst									Problem at Best

Today's Date:________ Today, I am at a:

1	2	3	4	5	6	7	8	9	10
Problem At Worst									Problem at Best

APPENDIX H

The BASC System Scale Definitions

(All definitions from Reynolds & Kamphaus, 1992, p. 48)

The Parent and Teacher Rating Scales

Adaptability: The ability to adapt readily to changes in the environment.

Anxiety: The tendency to be nervous, fearful, or worried about real or imagined problems.

Aggression: The tendency to act in a hostile manner (either verbal or physical) that is threatening to others.

Attention Problems: The tendency to be easily distracted and unable to concentrate more than momentarily.

Atypicality: The tendency to behave in ways that are immature, considered 'odd,' or commonly associated with psychosis (such as experiencing visual or auditory hallucinations.

Conduct Problems: The tendency to engage in antisocial and rule-breaking behavior, including destroying property.

Depression: Feelings of unhappiness, sadness, and stress that may result in an inability to carry out everyday activities (neurovegetative symptoms) or may bring on thought of suicide.

Hyperactivity: The tendency to be overly active, rush through work or activities, and act without thinking.

Leadership: The skills associated with accomplishing academic, social, or community goals, including, in particular, the ability to work well with others.

Learning Problems: The presence of academic difficulties, particularly in understanding or completing schoolwork.

Social Skills: The skills necessary for interacting successfully with peers and adults in home, school, and community settings.

Somatization: The tendency to be overly sensitive to and complain about relatively minor physical problems and discomforts.

Study Skills: The skills that are conducive to strong academic performance, including organizational skills and good study habits.

Withdrawal: The tendency to evade others to avoid social contact.

The Self Report of Personality Scales

Anxiety: Feelings or nervousness, worry, and fear; the tendency to be overwhelmed by problems.

Attitude to School: Feelings of alienation, hostility, and dissatisfaction regarding school.

Attitude to Teachers: Feelings of resentment and dislike of teachers; beliefs that teachers are unfair, uncaring, or overly demanding.

Atypicality: The tendency toward gross mood swings, bizarre thoughts, subjective experiences, or obsessive-compulsive thoughts and behaviors often considered 'odd.'

Depression: Feelings of unhappiness, sadness, and dejection; a belief that nothing goes right.

Interpersonal Relations: The perception of having good social relationships and friendships with peers.

Locus of Control: The belief that rewards and punishments are controlled by external events or other people.

Relations with Parents: A positive regard towards parents and a feeling of being esteemed by them.

Self-Esteem: Feelings of self-esteem, self-respect, and self-acceptance.

Self-Reliance: Confidence in one's ability to solve problems; a belief in one's personal dependability and decisiveness.

Sensation Seeking: The tendency to take risks, to like noise, and to seek excitement.

Sense of Inadequacy: Perceptions of being unsuccessful in school, unable to achieve one's goals, and generally inadequate.

Social Stress: Feelings of stress and tension in personal relationships; a feeling of being excluded from social activities.

Somatization: The tendency to be overly sensitive to, experience, or complain about relatively minor physical problems and discomforts.

APPENDIX I

Informal Behavioral Checklists

Behavior Checklist Cover #1

Teachers:

Please fill out the attached behavioral checklist on _____,

and return to Jennifer Demmons by_____.

**For every problem behavior you check, please rate the behavior on a scale from 0 to 10, 0 being the problem never occurs, and 10 being the problem always occurs and to an extreme degree.

Behavior Checklist Cover #2

Teachers:

Please fill out the attached behavioral checklist(s) on _____,

and return to Jennifer Demmons by_____.

**I have attached a copy of the first informal behavior checklist you completed on this student prior to the group. For every problem behavior you checked and rated, please provide a second rating on a scale from 1 to 10, 1 being the problem never occurs, and 10 being the problem always occurs and to an extreme degree.

Thank you!

Behavioral Concerns

Inattentiveness

- ❑ Daydreams
- ❑ Short attention span
- ❑ Easily distracted
- ❑ Often off-task

Impulsivity/Hyperactivity

- ❑ Squirms in seat
- ❑ Taps foot, pencil
- ❑ Blurts out answers
- ❑ Rushes through work
- ❑ Makes careless mistakes
- ❑ Trouble keeping hands, feet, objects to self
- ❑ Makes inappropriate comments
- ❑ Often leaves seat

Inappropriate Social Interactions

- ❑ Few or no friends
- ❑ Disrespectful of others' things
- ❑ Bossy
- ❑ Feels picked on
- ❑ Trouble sharing
- ❑ Trouble keeping personal boundaries
- ❑ Difficulty following rules in games
- ❑ Tattles
- ❑ Withdrawn, shy
- ❑ Unable to work in small groups
- ❑ Provokes or agitates others

Aggressiveness

- ❑ Bullies other students
- ❑ Explosive temper
- ❑ Verbally aggressive
- ❑ Physically aggressive
- ❑ Rebellious if disciplined

Frequent Violations of School Rules

- ❑ Bus violations
- ❑ Lies
- ❑ Noncompliance with directives
- ❑ Shows off (brags, clowns, etc.)
- ❑ Takes objects that do not belong to him
- ❑ Damages school property
- ❑ Leaves room/school without permission
- ❑ Copies from others
- ❑ Frequent unexcused tardies/absences
- ❑ Inappropriate seat behavior
- ❑ Does not raise hand when appropriate

Inappropriate Emotional Behaviors

- ❑ Looks sad, rarely smiles
- ❑ Pessimistic attitude
- ❑ Easily upset, feelings hurt
- ❑ Worries excessively
- ❑ Appears nervous
- ❑ Lacks energy, motivation
- ❑ Temper tantrums
- ❑ Excessive whining, or crying
- ❑ Explodes under stress
- ❑ Perfectionistic

APPENDIX J

Exit Interview Questions

1. Tell me about the problem you decided to work on in group and why you chose that problem.

2. How did the problem change as the group went on?

3. What do you think caused the change (or lack of change) to happen?

4. What did you learn from the group?

5. What did you like best about the group?

6. What do you wish were done differently about the group?

7. Would you say the group was useful to you, and, if so, how?