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Using Solution-Focused Brief Therapy with Problem Students

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USING SOLUTION-FOCUSED BRIEF THERAPY WITH PROBLEM STUDENTS

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B.A.

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Abstract

The traditional approaches of spending hours of time addressing each student's problems is no longer feasible today due to the large caseloads of students school counselors and teachers often face. Solution-Focused Brief Therapy is an approach which may be used for typical student concerns to achieve rapid observable change. School administrators and teachers will also benefit since each component of the approach may be used independently in a variety of situations. This thesis describes an outcome study of solution-oriented strategy in working with middle school students identified by teachers as having behavioral difficulties in the classroom. Subjects involved were a sample of twenty-eight middle-school classroom teachers. Fifteen or more teachers made-up the 'experimental group' with specific interventions initiated. In a workshop-type format, the teachers received instructions on how to utilize seven basic approaches in solution-focused therapy which they immediately incorporated in their interventions with a student they identified they would like to work with. The evaluation of the BSFT workshop is shown in Appendix D. The remaining half of the teachers were the control group without any given intervention. The independent variable relevant to this study is a solution-focused approach to behavior problems. The dependent variable is the change in student behavior as measured by teacher rating on the Conner Behavior Scale-Revised. This was carried out by administering a pretest measuring student behavior prior to the intervention and a posttest measuring the same variable following it.

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Introduction

Background to Study

To select teaching as a career is a decision affecting the lives of many people. Children and parents are most directly affected and the well-being of the community, in turn, is enhanced or diminished by the attitude and performance of its teachers.

A bill was recently introduced in the Missouri Legislature stating that all pre-service teachers must have, as a part of their teacher education program, a course dealing with student anger management or conflict resolution, H.B. 1327, Missouri House of Representatives, Spring 2000. In the past five years there has been an alarming increase in school violence at every level. Thus, there is the need for training for teachers who are already in the profession and have never been introduced to a solution-focused process that addresses these critical areas. Teachers and counselors alike are overwhelmed with assigned responsibilities and find little time to counsel students experiencing problems.

Whenever teachers find themselves stuck or at an impasse with a student or group of students, it is almost always the case that they are continuing to apply sensible, reasonable and well-tried strategies for dealing with the situation - but these strategies are not working. Often, the task amounts to finding ways to get the teachers to stop doing what isn't working and do something different. Many

classroom difficulties are viewed in this light and effective intervention can be achieved by encouraging the teacher to behave differently. The teacher and counselor might then discuss a strategy that involves doing something that is not part of the usual pattern of the problem interaction (Durrant, 1995).

Applications of counseling theories have traditionally focused on the skills and resources of the therapist to identify pathology and provide client systems with alternative methods of coping with life difficulties. From these traditional theories there appears to be a search for an answer of why people act the way they do. Although asking why may be the client system's agenda, Solution-Oriented Systemic (SOS) Therapy asks a different question: What changes are necessary to resolve a client system's conflict (Bateson & Bateson, 1989)?

As Bateson (1989) suggests the SOS therapist takes a future orientation of what is possible and the potential of a system to solve its own problems with the resources available to it without a need to know why. As the assumptions of traditional therapies are being challenged with new perspectives, a flicker of hope appears with the development of a new counseling model that seems ideally suited for schools. This recent approach, called Solution-Focused Brief Counseling (SFBC), shows promise because it focuses on students' assets rather than their deficits. Only a few meetings are needed to help students get on track to resolve their issues. This program replaces those which typically emphasize theoretical models of counseling that require longer-term therapy than school counselors have time to offer or that school districts want for their students (Bateson & Bateson, 1989).

As personnel use this new model to change their focus from problems to solutions, they begin to notice a change in the students. They seem more confident as they begin to recognize their strengths and resources that were previously unnoticed. They observe their students repeating their successes, which in turn beget other successes (Durrant, 1995).

Sometimes, people say that a focus on competence and "exceptions" are an unrealistic stance (Durrant, 1995). Given the day-to-day pressures of the classroom activities, some may think that these ideas amount to viewing troublesome students through "rose-colored glasses." Nevertheless, the glasses used can actually make a difference. The way one chooses to view the students with whom they work may actually affect their behavior. The assertion is that, by focusing on competence and strength, better teaching methods will emerge resulting in more student success and ultimately contribute positively to society.

This research is supported with recent documentation by Sheri Eisesngart (1998) in her study of Solution-Focused Brief Therapy: A Review of the Outcome Research, in which she gave a review of fifteen controlled outcome studies reported in literature up through 1998. The results of the studies were summarized along with key dimensions. Five of the studies were conducted within school settings.

Briefly, the results stated that thirteen of the fifteen reported that Solution-Focused Brief Therapy resulted in improved client outcomes - two studies did not report pre-post results for Solution-Focused Brief Therapy clients. A more stringent test of effectiveness is to ask whether Solution-Focused Brief Therapy is

as good as or better than standard treatments. Eleven studies allowed such a comparison, and in seven of the eleven studies Solution-Focused Brief Therapy equaled or surpassed the outcomes of the standard treatment. Solution-Focused Brief Therapy sometimes produced better outcomes, and sometimes it produced comparable outcomes in less time. Only one study failed to report any positive outcomes for Solution-Focused Brief Therapy. The review concluded that the analysis provided strong initial support for the effectiveness of Solution-Focused Brief Therapy. While past research has shown positive conclusions about the effectiveness of BSFT, in general, not much research has yet been specifically directed at the use of this method within the school setting and its effects on those students with deviant behaviors in particular.

Statement of the Problem

The purpose of this study was to examine the efficiency of using the positive intervention of Solution-Focused Brief Counseling to improve students' negative behavior in the classroom. This research was interested in examining whether teachers adopting a solution-focused approach may impact and facilitate student success. Subjects involved were twenty-eight middle-school classroom teachers. Fourteen made-up the 'experimental group' with specific interventions initiated. In a workshop-type format, the teachers received instructions on how to utilize seven basic approaches in solution-focused therapy. These approaches were to be used as interventions with a student that they had previously identified. The seven interventions taught included: reframing; pattern interruption; observational tasks; practicing success; pretend tasks and do something different.

The two testing instruments and memos on usage were also distributed and reviewed before the workshop concluded. (See Appendix B) Following the date of the initial workshop, three more meeting dates were established to assist in any concerns or questions that might arise later. (See Appendix B) The evaluation of the BSFT workshop is shown in Appendix D. The remaining half of the teachers were the control group without any given intervention. The independent variable relevant to this study was a solution-focused approach to behavior problems. The dependent variable was the change in student behavior as measured by teacher rating on the Conner Behavior Scale-Revised. This was carried out by administering a pretest measuring student behavior prior to the intervention and a posttest measuring the same variable following it.

Hypothesis

The hypothesis being examined in this study is:

There was a significant reduction in teacher's reports of students' negative behaviors with the teachers who utilize solution-focused brief strategies with students when compared with those teachers who do not utilize solution focused interventions.

Chapter II

Literature Review

Introduction

In this chapter the results of a review of the literature related to the problem investigated in this study are presented. Literature related to brief-solution focus theory and definition was considered in the first section while literature examining the application of a solution-focused approach for schools was reviewed in the second section.

Brief-Solution Focus Theory and Definition

Historically, the most influential figure of solution-oriented therapy was Milton H. Erickson who, as early as medical school, challenged traditional beliefs of the potential of human beings (Erickson, 1954). He believed in the power of the unconscious to harness positive resources which guide the person to solutions that fit the unique problem presented. Erickson also believed that the individual will do what is necessary to survive in the system and the symptoms expressed are an individual's way of coping in his or her environment. Erickson cautioned therapists who wanted to take symptoms away from their clients (Haley, 1985) and saw this as "the solution".

Boscolo and Cecchin (1982) warned novice therapists to avoid coming to conclusions about the cause of symptoms and instead, encouraged the formulation of as many plausible explanations as possible. It is up to the system to choose the

solution that best fits its situation and choose a particular path (out of many paths) to reach a solution. Paths that do not provide the desired result are not considered failures, but learning experiences of now familiar territory.

The traditional approach to Brief Therapy has been to focus on problems and problem solving thereby stopping the clients' complaint or problem. An important aspect of this approach involved identifying the behaviors which perpetrate the problem and help the client to discontinue them (de Shazer, 1982). However, recent work in this area suggests that this traditional approach may not be the best method of looking at solutions.

The Brief Family Therapy Center of Milwaukee appears to be presenting the majority of the literature pertaining to solution-oriented psychotherapy. This movement was led by Steve de Shazer (1982; 1985; 1988; de Shazer & Berg, 1988) who emphasized the concept of "fit" by Korzyski (1941) with his "skeleton key" solutions to interventions that focus on solutions and recognizes the value of exceptions (de Shazer, Berg, Lipchik, Hunnally, Molnar, Gingerich, & Weiner-Davis, 1986). In solution focus, solutions may also be examined in relation to goals of the client. In this way, solutions are the means by which the "client does something different to become more satisfied with his or her life" (de Shazer, p. 51). This way of thinking suggests that the nature of solutions is of greater significance than the nature of complaints (de Shazer, 1985).

As a pioneer in the field of Brief Therapy, Steve de Shazer describes an approach as stating the basic assumption which makes the nature and implication of the solution more evident. He describes the complaint presented as "having a

restricted set of behaviors, perceptions, thoughts, feelings, and expectations. Any exceptions of behaviors, perceptions, thoughts, feelings, and expectations outside the constraints of the complaint can be used as building blocks in the construction of a solution" (de Shazer, p. 49). Therefore, as a solution focused therapist, one talks about changes that make a difference, and solutions instead of difficulties, complaints and problems. In short, solutions involve discovering what "works," so that the client may do more of it. In order to further their understanding of solution development, the B. F. T. C. has been interested for many years in transferability of interventions, particularly homework tasks, from one case to another. This focus on the transferability of tasks trains one to observe and describe patterns or similar sequences of events (de Shazer, 1985).

This sameness is necessary in helping the observer to notice anything different. This process of solution development then, can be summarized as "helping an unrecognized difference become a difference that makes a difference" (de Shazer, p. 10).

Another change initiated at B. F. T. C. is quickly taking a look into the client's future by using "the miracle question sequence" (de Shazer, p. 5). This method of indirectly asking about goals consistently brings out descriptions of concrete and specific behaviors, thereby, helping clients set goals and tell how they will know when the problem is solved. When a solution develops from a structural view of the problem, then the structural view proved itself useful (de Shanzer, p. 7).

Walter and Peller further define the solution-focused approach as they

reveal how, in the past hundred years, therapy models have been developed through the historical progression of assumptions based upon an initial struggle or question. By their very act of "asking the questions, developers preselected directions toward particular answers or classes of answers" (Walter & Peller, p. 1). Therefore, these ideas and trends progressed into therapy models from the assumptions drawn from within the original questions (Walter & Peller, 1992).

Examples of past questions include: 'What is the cause of the problem?' and 'What maintains the problem?'. These questions purpose that, not only is there a definite problem, but that there is a specific cause to that problem, and that the problem is being maintained (Haley, 1980; Madames, 1981; Minuchin, 1978).

In recent years, a new and different question is being asked: "How do we construct solutions?" The presuppositions within this question are: that there are solutions; that there is more than one solution; that they are constructable; that we (therapist and client) can do the constructing; that we construct (invent) solutions rather than discover them; and that this process(es) can be articulated and modeled (Walter & Peller, 1992).

There are three primary steps in the solution-focused approach: "How do we construct solutions?" Very simply: One, define what the client wants rather than what he or she does not; two, look for what is working and do more of it; three, if what the client is doing is not working, then have him or her do something different (Walter & Peller, 1992).

Walter and Peller (1992) built upon previously established assumptions of the solution-focused approach described by de Shazer, Berg, 1996; de Shazer,

1988; O'Hanlon & Weiner-Davis, 1989; Peller & Walter, 1989. These are their current working assumption and definitions: Advantages of a Positive Focus (Assumption: Focusing on the positive on the solution, and on the future facilitates change in the desired direction. Therefore, focus on solution-oriented talk rather than on problem-oriented talk.); Exceptions Suggest Solutions (Assumption: Exceptions to every problem can be created by therapist and client, which can be used to build solutions); Nothing is Always the Same (Assumption: Change is occurring all the time.); Small Change is Generative (Assumption: Small changing leads to larger changing.); Cooperation is Inevitable [Assumption: Clients are always cooperating. The clients are showing us they think change takes place. As one understands their thinking and act accordingly, cooperation is inevitable (de Shazer, 1982, 1985, 1986; Guilligan, 1987)]; People Are Resourceful (Assumption: People have all they need to solve their problems); Meaning and Experience Are Interactionally Constructed (Assumption: Meaning and experience are interactionally constructed. Meaning is the world or medium in which we live. We inform meaning into our experiences and it is our experience at the same time. Meaning is not imposed from within or determined from outside of ourselves. We inform our world through interaction.); Recursiveness (Assumption: Actions and descriptions are circular.); Meaning Is In The Response [Assumption: The meaning of the messages is the response you receive (Bandler & Grinder, 1979; Dilts, 1980).]; The Client Is The Expert (Assumption: Therapy is a good-or solution-focused endeavor, with the client as the expert.); Unity (Assumption: Any change in how clients describe a goal

(solution) and/or what they do affects future interactions with all others involved.); and Treatment Group Membership [Assumption: The members in a treatment group are those who share a goal and state their desire to do something about making it happen (Walter & Peller, 1992).] These twelve assumptions are useful as a guide to ones thinking and actions, as well as, helping to provide the meaning and guidelines for this as a total approach, a way of thinking, conversing and interacting with clients.

Doctoral candidate at the Mandel School at Case Western Reserve University (1998) Sheri Eisengart has completed a review summary of all of the published outcome research on SFBT up through 1998. To be included in her review, the interventions had to be identified as solution-focused or solution-oriented brief therapy, as well as, referencing in the reports the writings of de Shazer and the Milwaukee group. The core conditions of SFBT used in the interventions were also from de Shazer and Berg and the proposed research protocol of the European Brief Therapy Association. The study also was required to meet three other criteria to be included in their review: it employed some form of experimental control; it assessed client behavior or functioning (not satisfaction); and it looked at end-of-treatment or follow-up outcomes. The review covered fifteen controlled outcomes. The complete reference for each study is given. The results of the review were: thirteen of the fifteen reported studies in literature through 1998 show that SFBT resulted in improved client outcomes - two studies did not report pre-post results for SFBT clients; eleven of the studies allowed a more stringent test of effectiveness and asked whether SFBT is as good

as or better than standard treatment, and in seven studies SFBT equaled or surpassed the standard treatment outcomes, sometimes producing comparable outcomes in less time; and only one study (Littrell et al, 1995) failed to report any positive outcomes for SFBT. The author concludes that the box score analysis provides strong initial support for the effectiveness of SFBT (Eisengart, 1998).

Application of Solution-Focused Approach for Schools

As stated earlier, brief forms of counseling and psychotherapy are becoming increasingly popular. Once viewed as less valuable than long-term treatment, short-term approaches have become recognized as valuable today (Wells & Giametti, 1990). Fisher (1984) is one who demonstrated the efficiency of brief therapy. School counselors have many different roles to assume and have routinely practiced brief forms of counseling by adapting non-short-termed counseling theories (Nivens, 1989).

As a development recently in brief therapy literature, through Steve de Shazer's writings and those of the Brief Family Therapy Center group, the solution-focused counseling approach has been brought into the forelight. This therapeutic approach and others influenced by the work of Milton Erickson offers numerous straight forward approaches for counselors. The interventions used are designed to help counselors focus on client's strengths that can be used to find meaningful solutions to problems. The de Shazer group developed a set of principles that guide this solution-based approach (Zimstrad, 1989): major task of counseling is to help the person do something different; focus on the problem is redirected toward solutions already existing; only small change is necessary

because any change creates the context for further change; and goals are framed in positive terms with an expectancy for change.

A useful intervention with teachers who seem overly focused on the negative behavior or what they view as negative personality traits of a student is to have the counselor ask the teacher (as well as the student) "What is the smallest amount of change in behavior that you could notice that would tell you that a change for the better has started?" This can help clients notice the exceptions to the problem (Bonnington, p. 4). This was described by Bateson (p. 27) as a "a difference that makes a difference," as a small change of behavior in one person is noticed by another who then changes his or her response that then influences the first person to change more. Another way to focus on strengths is by focusing on what is already working (de Shazer & Molnar, 1984). One of the most interesting interventions developed by de Shazer and colleagues is known as 'the miracle question' in which the person asked the question is able to bring more of their non problem-focused experiences into use (de Shazer, 1991).

Furthermore, by using a careful choice of words one can carry the implication that the problem will not be a problem or will be less of one in the future (de Shazer, 1991). The tasks of this approach are summarized as follows: eliciting news of difference; amplifying the differences; and helping changes to continue (Nunnally, de Shazer, Lipschik & Berg, 1986). Combining this approach with relationship skills, which are a major part in the counseling relationship, can create many opportunities for counselors to be helpful (Bonnington, 1993).

Kral (1987) referred to this as 'individual' therapy methods which made use of existing strengths and abilities and inferred this to be a very effective means in establishing behavioral changes in students and may be the treatment of choice for student problems. Reasons a parent, administrator or teacher would choose indirect therapeutic methods may vary. Some may want the simplest way available to resolve immediate problems by doing something they already know how to do or have done before, some may lack the necessary motivation to learn a new technique and still others may perceive no need for treatment believing the child "needs to get their act together" (p. 19). Most indirect therapeutic interventions in school are directed at adults (teachers, administrators, and parents) since they have available to them a wider range of responses, greater motivation for change and more power within the situation than students generally have. A variety of techniques are available to intervene at this level such as: reframing; stories; experiments; and positive blame. The purpose is to use these techniques to bring a difference in the system which will result in changed behavior on the students part (Kral, 1987).

Certainly the same or similar approaches could be used with individual students. Metcalf (1995) wrote a handbook for teachers, administrators and school counselors who desire to use the more positive method of solution-focused approach when dealing with school populations. The ideas developed in her book are based on the principles of solution-focus brief therapy that focus on solutions rather than problems in their approach. By using this approach, interventions used in the school setting will be more effective and less stressful. The program

stresses noticing the "exceptions" to when the problems do NOT occur and when THEY occur. By doing so, this can initiate a change (difference) in ones perspective of oneself (Metcalf, 1995).

This approach, Solution-Focused Brief Therapy, used by many private therapists and counselors is now being applied in school with great success. Metcalf's (1995) program is designed to bring about change in individual's behavior, thus empowering students of all ages to deal with their own problems and gain self-esteem in the process. Here are the outstanding features of her book: changing our thinking to a solution focus; creating possibilities through language; competency-based conversations; the "exceptional" school program (thinking about students differently); combining your resources; turning impossibilities into possibilities (ideas for difficult situations); turning attitudes into resources (ideas for classroom guidance); behavior transformations: disciplining differently; and a solution-focused school staff: creating the atmosphere.

Similarly, Durrant (1995) in the same timeframe as Metcalf, described creative strategies for school problems. His recommended solutions for psychologists and teachers included: how do we think about school problems; and changing behavior and meaning.

The book focuses on what to do, rather than what caused "the problem"; for example: assessing competence; assessment information from teachers; assessment with students; assessment for intervention; and Kral's (1998) "5 'D' Process" (p 45). Durrant not only demonstrates strategies for assessment but shares thoughts and ideas used for setting goals, intervening in problem behaviors,

highlighting change and shifting the focus from present problems to future solutions.

Sklare's (1997) purpose in writing Brief Counseling That Works: A Solution-Focused Approach For School Counselors was to provide a step-by-step instruction on how to use solution-focused brief counseling with elementary and secondary students. School counselors, in particular, along with school administrators and teachers would benefit because each component can be used independently and in a variety of situations. These skills of conducting 'solution-talk discussions' with students can help educators reduce arguments, improve relationships and teach young people to assume responsibility and make better decisions in such a supportive environment.

Solution-Focused Brief Therapy is ideally suited for schools because it overcomes many of the 'pitfalls' which impede school counselors (Sklare, 1997). With large caseloads of students, counselors find little time for providing needful students with long-term traditional counseling. Also, today more than ever, counselors need an approach which is suitable for a broad range of problems. With increased pressure for accountability more recently, counselors need an approach that leads to rapid observable change in students (Sklare, 1997).

Sklare's (1997) book is based on the work of de Shazer (1985), who developed the BSFC approach. He discovered that by focusing on solutions rather than problems clients were getting better faster than with traditional counseling methods. Crucial to this model is the belief that clients are not always overcome by their problems. The fact is that, solutions are actually present even though they

may be unrecognized. By rediscovering their resources, clients are encouraged to repeat past successes. As simple as it seems, it is a powerful, empowering dynamic that enables clients to quickly resolve the difficulties which lead them to counseling (Sklare, 1997). Areas covered in his text included: counseling in schools: problems and solutions; setting goals; and discovering and constructing solutions.

Paul and McGrevin (1996) also emphasized the significance of the solution-focused conversational leader in the school setting. It is primarily in conversations that administrators lead; therefore, the assumptions one brings to a conversation matter greatly. The solution-focused conversational leader begins with the belief that there are solutions and listens to their own words and the words of others carefully because they know, that, ultimately, the words of each either empower the problem or the solution (Paul & McGrevin).

The author, Murphy (1997), from his excerpt from "Solution-Focused Counseling in Middle and High Schools," divides his writing into two parts:

Part I - Describes the empirical foundations of solution-focused counseling in schools by reviewing pertinent research and literature in the following areas: factors that enhance counseling outcomes; and brief therapy.

Time-limited counseling is supported by a large body of research done by Budman & Gurman; Koss & Butcher; Koss & Shiang; Luborsky, Singer, & Luborsky; Orlinsky & Howard indicating no reliable differences in effectiveness between long-term and short-term individual therapy. Garfield's (1994) extensive research on client variables offers some important clues as to why brief therapy

works. First, most people seek help to resolve a specific, current problem rather than to gain insight, overhaul their personalities, or explore the past. Second, the majority of people who enter counseling expect that only a few sessions will be required. These findings are relevant to school practitioners in that most school counseling referrals involve a specific concern and complaint about a student, teacher, or parent, such as low grades or behavior problems, and a desire for rapid change. The practitioner's respectful accommodation of the client's goals and expectations may, in part, be the reason for the effectiveness of time-limited approaches such as solution-focused counseling (Murphy, 1997).

Part II - Looks at collaborative problem solving in schools; cultural considerations; and counseling adolescents. It also offers some practice exercises for the counselor/therapist: collaborative problem solving in schools; cultural considerations and solution-focused counseling; and counseling adolescents.

Going a step further, Corcoran (1998), takes a look at solution-focused practice with at-risk youths of middle and high school. She explains a solution-oriented approach to practice with students that have been referred to the school social worker for academic or behavioral difficulties in the classroom. The importance of placing emphasis on student's strengths and resources, as well as, the importance of context for the shaping of individual behavior are discussed. In addition, solution-focused practices, such as identifying exceptions to the problem, goal setting, scaling questions and narrative interventions are explained with examples pertinent to practice with this population.

Finally, the author Jacqueline Corcoran (1998) explores issues relevant to applying the solution-focused model with teachers and family members. Techniques may include (p 241): showing empathy; developing resources; identifying goals; and identifying exceptions.

Authors Dielman and Franklin (1998) explain the benefits of Brief Solution-Focused Therapy in helping youths diagnosed with attention deficient hyperactivity disorder (ADHD). According to DSMII (American Psychiatric Association, 1994) students with ADHD have significant problems in sustained attention and concentration or problems with excessive activity, restlessness and impulsiveness. These students have experienced a history of academic failure, in addition to marked difficulties in social relationships. Psychologically, these adolescents may be more likely to struggle with poor self-concept, depression and concerns about school completion (Barkley, 1990; Flick, 1996). Consequently, adolescents with ADHD often associate with peers who have similar problems and together engage in more risk-taking behaviors (Flick, 1996).

Adolescents with ADHD are more likely to have other behavioral diagnosis (i.e. oppositional defiant disorder or conduct disorder), have more difficulty managing academic tasks (i.e. study habits, organized activities, managing varying class schedules, and balancing social versus school demands) and staying in their homework without becoming bored and rushing through with little consideration (i.e. neatness, accuracy and completion). The authors discuss

effective practice approaches with the BSFT model based upon the past work of de Shazer, Berg, Miller), and their colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin.

Research indicates that a multi-model intervention approach is essential for the management of adolescents with ADHD. Authors conclude that the brief solution-focused therapy provides a positive, multi-model approach and can be useful when working with adolescents with ADHD and their families (Dielman & Franklin, 1998). The authors cite a case example where the solution-focused therapy model is used along with the use of psycho-stimulant medication (Pinsof, 1995) and involvement of parents in the process (Barkley, Guevremont, Anastopaulos & Fletcher, Ziegler & Holden) with an adolescent with ADHD and his family and reveal the progress he made over time in terms of behavioral self-control.

The subject of a solution-focused school is addressed by Davis and Osborn when they propose the question of "How can a school be transformed from a problem-focused environment to a solution-focused environment, one that fosters and highlights positive change?" (p. 31) Solution-focused counseling represents a positive and competency-based perspective on the problems experienced by individuals and by organizational systems (schools). Rather than looking for what's wrong and how to fix it, this approach looks for what is already working and investigated how to use it.

The five principles described below are used to capture the essence of a solution-focused approach and represent a preliminary model for cultivating and

promoting solution-focused schools (Davis & Osborn, 1999). The principles included were: salutary centerpiece [The problem is the problem, not students, or teachers, or parents (Metcalf, 1995). The educator "redescribes" the problem in a normalizing manner.]; exceptional ingredients;]Identifying and highlighting "exceptions," or non-problem occurances. Problem "irregularities," as they are sometimes referred to (Miller, 1992), represent occasions or "windows of opportunity," when the problem is not happening.]; using utilities; [Finding and using familiar, past coping strategies which worked before (i.e. strengths, talents, abilities, accomplishments) to help construct a new and workable solution (Sklare, 1997).]; cooperation is key [We can attempt to align ourselves with students and empathize with them in such a way that allows them to feel heard and understood (Short & Greer, 1997).]; and the ripple effect [When behavior is positively altered, no matter how slightly, it causes a chain reaction (Sklare, 1997).]

Most recently, in The Application of Solution-Focused Brief Therapy in a Public School Setting, the author, Williams (2000), expresses his concerns about the traditional misplaced 'blame' of the problems schools face and the past failures of therapies tried. In 1995, he became part of a program in the Hamburg Public School District of Hamburg, New York, called Family Support Center, which committed to do family counseling in schools in collaboration with six human service agencies. The model they choose to best suit their needs was Solution-Focused Therapy. By implementing this model they learned: the techniques (scaling, miracle question, and wording the presupposed change) are not magical, but contributors to change; brings confidence and energizes both

client and staff members (hope and expectancy); the search for strengths of clients has a positive effect on staff; clients sense the confidence of staff; 'empowering' of the clients to discover their own strengths increases the staffs confidence in dealing with more challenging professional issues; in schools there is more optimism and higher expectations for their students; and there is a 'rippling effect' evident in the schools (Williams, 2000).

Summary

A review of the literature suggested that by using the application of various techniques employed by brief solution-focus therapy there would be a significant reductions in students' negative behaviors in the classroom. As the traditional approach in BSFT, of focus being on problems and problem solving, evolved into one in which the focus became one of solutions and exceptions, recognized leaders in the field began recognizing the value of this method as a short term treatment for school environments. The purpose is to use the various techniques to bring about a difference in the system which will result in changed behavior on the students part. Handbooks have been published for teachers, administrators and school counselors who desire to use this more positive solution-focused approach when dealing with school populations. This approach, BSFT, used by many private therapists and counselors, is now being applied in schools with great success.

Hypothesis

There will be a significant reduction in students' negative behaviors with those teachers who utilize positive intervention with students as opposed to those teachers who do not utilize these interventions.

Chapter III

Methods

Participants

In this study the sample was comprised of twenty-eight subjects who were divided into two groups. The first group of fourteen subjects were the experimental group who received an intervention. The second group of fourteen subjects, the control group, did not receive any intervention throughout the research process.

The subjects were drawn from the population of eighty-seven educators at the middle school level who have either a Bachelor's or Master's degree in the educational field. The research sought volunteers from the same middle school building within a specified district in the county of St. Charles. The majority of participants were from an average socioeconomic status. The range of ages varied from twenty-five to fifty years of age. The sample predominantly consisted of white, female subjects.

Volunteers from a total school population of eighty-seven were sought to form this pool of teachers. Twenty-eight teachers volunteered to participate in the study. Fourteen were assigned to the experimental group and fourteen to the control group. Each teacher identified two students using a student behavior rating form consisting of twelve specific criteria (See Appendix A). One source of sampling bias within this research plan is the fact that this study is limited to the

population of teachers in one suburban middle school within a St. Charles County school district. As such, the majority of the sample was predominantly comprised of white, female subjects.

Instruments

This research study on Brief Solution-Focused Therapy utilized one instrument, Conners' Behavior Rating Scale (Conners, 1999). The Conners' Behavior Rating Scale was used to measure the change in students behavior, both before and after the intervention of solution-focused strategies have been administered by classroom teachers. This instrument has been designed to report on youths ages 3 to 17 years old on childhood and adolescent psychopathology and problem behavior. The CTRS-R:L (Conners' Teacher Rating Scale-Revised: Long Form) is typically used with cooperative teachers who have time to complete the long form and when extensive information is required. Sample items on the checklist include the following: "Appears to be unaccepted by group," "Poor in spelling," "Not reading up to par," and "Interrupts or intrudes on others." When responding, teachers are supposed to consider the child's behavior and actions during the past month. The scale contains 59 items and covers the following subscales: Oppositional (6 items), Cognitive Problems/Inattention (7 items), Hyperactivity (7 items), Anxious-shy (6 items), Perfectionism (6 items), Social Problems (5 items), Conners' Global Index (10 items), Restless-Impulsive (6 items), Emotional Liability (4 items), ADHD Index (12 items), DSM-IV Symptoms Subscales (18 items), DSM-IV Inattentive (9 items), DSM-IV Hyperactive-Impulsive (9 items) (Conners, 1999).

The Conners' Teacher Rating Scale-Revised: Long Form contains rationally derived subscales that relate directly to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria. The new DSM-IV Symptoms subscale can be scored in terms of straight symptom count or can be scored in comparison to norms. Subscales are included on the CRS-R (Conners' Rating Scale-Revised) forms to help assess the child in a variety of areas. The CRS-R, therefore, helps to assess not only ADHD, but also conduct problems, cognitive problems, family problems, emotional problems, anger control problems, and anxiety problems (Conners, 1999).

The CRS has been around for 30 years in one form or another. The latest version, the CRS-R, adopted and refined the "pearls" and requisites from the previous versions and added new items and scales. The main goals of the CRS-R were to address requests and suggestions accumulated since the last publication in 19889, recognize the DSM-IV, include new normative data, and introduce the self-report scales to meet needs of mental health professionals, parents, teachers, and, ultimately the children now and into the next millennium. To meet these goals, the CRS-R was developed systematically and scientifically (Conners, 1999).

A separate teacher checklist was developed to provide behavioral and academic information from the school setting. The teacher form included items related to classroom behavior, group participation, and attitude towards authority. From early on, it was evident that both the parent and teacher scales had excellent

research properties. For example, the very first study on the teacher rating scales (Conners, 1969) found adequate test-retest reliability (Conners, 1999).

Evolution of the scales continued until 1989, when final refinements were made and the scales were formally published. The publication of the CTRS made them much mroe widely accessible and gave many researchers and practitioners the opportunity to use these scales both empirically and clinically. In fact, the Conners' Rating Scales have become among the most widely used child behavioral rating scales in the world. Literally hundreds of research studies have validated the Conners' Rating Scales (Conners, 1999).

There were many reasons for the restandardization of the Conners' Rating Scales. However, there were three primary purposed for their revision. They included: to align the Conners' Rating Scales with DSM-IV; to update the norms and provide a large representative normative sample; and to add an adolescent self-report scale to complement the parent and teacher scales (Conners, 1999).

Prior to releasing this revised version of the CRS; many years of research were undertaken to establish norms, reliability, and validity for the CRS-R. For the parent and teacher forms, separate norms are available for boys and girls in 3 year intervals, for ages 3 through 17. For the new self-report forms, separate norms are available for boys and girls, in three intervals for ages 12 through 17. The CRS-R were normed on several large samples of children and adolescents. The author accumulated approximately 11,000 cases in the database and used over 8,000 cases in the normative sample. The data was collected by site coordinators from over 200 schools in 45 states and 10 provinces throughout the U.S. and

Canada. Ratings, as well as, information on ethnicity, sex, age, socioeconomic status, special populations, and geographic location were gathered (Conners, 1999).

In terms of reliability, internal consistency coefficients range around .75 to .90, and 6- to 8-week test-retest reliability coefficients range from about .60 to .90. In terms of validity, support for the validity of the structure of the CRS-R forms was obtained using factor analysis techniques on derivation and cross-validation samples. Convergent and divergent validity was supported by examining the relationship between CRS-R scores and other related measures, such as: a the Children's Depression Inventory (CDI); the Continuous Performance List (CPI); and the Conners' Rating Scale (CRS). Discriminate validity was also strongly supported by statistically examining the ability of the CRS-R to differentiate ADHD individuals from nonclinical individuals and other clinical groups (Conners, 1999).

The procedure for scoring and profiling the CRS-R long forms is very similar to the procedure used with the short form. Scoring the long form takes more time, and the profiling is done on a colored form (See Appendix A for the complete scoring procedure.) After the total raw score for each subscale is calculated, they are converted to T-scores using the age-related column. The T-score enables one to put the CRS-R raw scores into the context of the general population. By locating the corresponding T-scores in each of the given scales one can look at the student's profile and determine which categories are indicated as the child's problem areas.

The researcher chose this particular assessment understanding that the teacher scales usually provide the most economical and objective way to obtain relevant assessment information because they provide an ideal means for describing academic, social, and emotional behaviors in the classroom. The CRS-R has many advantages: a large normative data base, multidimensional scales that assess ADHD and comorbid disorders, links to DSM-IV, the Conners' Global Index, clinical and diagnostic relevance, the availability of teacher, parent, and self-report scales in long and short format, inclusion of both externalizing and internalizing items, applicability to managed care contexts, easy administration, scoring, and profiling of results, graphs to monitor progress, forms for providing feedback and presenting results, and excellent reliability and validity (Conners, 1999).

There are three possible threats to validity which should also be considered. Invalid input from CRS-R raters is likely to produce misleading results. First, random responding can result when individuals are poorly motivated or when there is a fixed time limit and respondents are struggling to finish in the given time. Raters may also have reading difficulties or may misunderstand the purpose of the ratings. Secondly, response bias also pose threats to validity. Teachers who want the child out of his/her classroom may intentionally or unintentionally bias their responses and present an overly negative picture. Lastly, sometimes a person's responses will contradict each other. The higher the number of such inconsistencies, the more likely it is that the responses are invalid and that the respondent was not motivated to give accurate responses (Conners, 1999).

There may be ways the researcher can help to guard against these possible threats to validity. For random responding the researcher can reassure the respondents of unlimited time restraints in completing the instrument and provide extra motivation by reiterating the positive benefits helped to be achieved by the experiment, for them personally. Reminding the responder, again to respond as accurately and objectively as possible to each rating to help avoid inconsistencies or invalid responses, will be helpful (Conners, 1999).

The second instrument utilized in this research was the Solution Identification Scale, a survey developed by Kral (1989) and reproduced with permission. The Identification Scale is composed of thirty-nine behaviors stated in a positive rather than a negative format. The scale was used to compare the behavioral change of each student from the pretest to posttest.

Procedures of the Research Plan

The Group Experimental Design was chosen by the researcher in this research study in which Brief Solution-Focus Therapy was applied to the negative behaviors of students. The true experimental group design has one characteristic that none of the other designs have - random assignment of participants to treatment groups. Also, all true experimental group designs have a control group. This design is appropriate in this type of research study as the purpose is to establish a cause and effect relationship between solution focused strategies and students' behavior problems; and most sources of threats to validity are controlled for.

The steps to be taken to execute this study begin with seeking volunteers from the pool of possible subjects. From this pool teacher subjects were assigned systematically to form two equal groups, an experimental and a control group. At the beginning of the second term of the school year the teacher selected students with whom the interventions were to be used, based upon a predetermined criteria. All students were then rated by their respective teachers on the Conners' Behavior Rating Scale-Revised prior to the intervention. The solution-focused strategy was then taught in a workshop type format to the experimental group and they were directed to use them for an established period of one month with the student they had preselected to receive the intervention. The workshops were designed as a series of four meetings within appropriate intervals of time, each lasting approximately 45 minutes. The initial meeting included: time to review the materials selected on B.S.F.T., time to go over specific interventions and goals; time to go over the forms included, and time to answer questions and hear concerns. The concept of B.S.F.T. was discussed, as well as, examples of how it might be applied and teachers were given two role-plays to practice. The three consecutive 'follow-up' meetings were, again, to respond to any questions/concerns the teachers might confront as they proceeded with the stipulated interventions. The teachers' attendance at each of these meetings ranged from 75% to 100%. The final meeting was used for teachers to turn in all completed materials and for teachers to evaluate the B.S.F.T. Plan. Upon the conclusion of the intervention time frame, a posttest was then administered with

the teachers rating their student on the Conners' Behavior Rating Scale-Revised to detect behavioral changes as a result of the intervention.

The best way to analysis the data was to compare the posttest scores of the two treatment groups. The pretest was used to see if the groups are basically the same on the dependent variable prior to the intervention, and if they were, posttest scores could be directly compared using a t-test to see if there was a significant difference in the CBRS-R scores of students whose teachers applied the solution-focused strategies and those whose teachers did not. However, since the randomization assumption of the t-test was not met, the Analysis of Covariant (ANC⊘VA) was used to compare the experimental and control groups' scores on the CBRS. ANC⊘VA compared the posttest mean corrected for any existing initial difference.

Another potential threat to the internal validity of the group design was the instrumentation, or the unreliability of measuring instruments. Thus, a proven test for reliability and validity, the Conners' Behavior Rating Scale-Revised was utilized for evaluation of results in this research study. Also, every effort was made to obtain reliability by explaining the CBS-R and how to rate the students by making sure that observational conditions (e.g., location, time of day, etc.) were standardized.

Chapter IV

Results

Descriptive statistics of subjects' responses to the Conners' are reported below in a comparison of both the pretest and postest of all the subscales.

Table 1: Means, standard deviation and sample sizes for the experimental and control groups on the Oppositional Scale of the Conners' Teacher Rating Scale-Revised.

Groups	Mean	SD	N
Experimental	70.60	14.57	25
Control	59.31	11.93	26

There was a numerical difference in the means of the experimental and control groups as shown in Table 1. Analysis of covariance was used to determine whether the resulting difference in means was statistically significant. The results of this analysis are shown in Table 2.

Table 2: Summary of Analysis of Covariance (ANC⊘VA) comparison of the experimental and control groups on the Oppositional Scale of the Conners' Teacher Rating Scale-Revised.

Source of Variation	Mean Square	df	F	P-Value
Experimental vs. Control	2238.723	1	33.214	.000
Within Groups (error)	67.404	48		
Total		49		

Teachers participating in the study were randomly selected. However, the students did not represent random samples. Therefore, Analysis of Covariance was used to compare the changed means of the experimental and control groups on each of the subscales of the Conners' Teacher Rating Scale-Revised. Analysis of Covariance also adjusts for any differences which may have existed initially between the experimental and control groups. Therefore, it tests for the difference in "corrected" measurement between groups. As shown by the data in Table 2, there was a significant difference ($p<.05$) between the experimental and control group's change in the manifestation of behaviors from the beginning of the study with the experimental group showing significant greater improvement. This variation can be attributed to Brief Solution Focus interventions initiated by teachers of the experimental group. Further results also indicate a significant correlation between the pretest and posttest scores as is required by the analysis of covariance.

Table 3: Means, standard deviation and sample sizes for the experimental and control groups on the Cognitive Problems/Inattention Scale of the Conners' Teacher Rating Scale-Revised.

Group	Mean	SD	N
Experimental	65.72	12.45	25
Control	64.70	11.17	26

As with the Oppositional Scale, the mean of the experimental and control groups show a numerical difference. ANC∅VA was used to determine whether the resulting difference in means was statistically significant. The results of this analysis are shown in Table 4.

Table 4: Summary of Analysis of Covariance (ANC∅VA) comparison of the experimental and control groups on the Cognitive Problem/Inattention Scale of the Conners' Teacher Rating Scale-Revised.

Source of Variation	Mean Square	df	F	P-Value
Experimental vs. Control	16.619	1	.292	.592
Within Groups (error)	56.962	48		
Total		49		

As shown by the data in Table 4, there was NOT a significant difference ($P<.05$) between the experimental and control groups change in the manifestation of behavior from the beginning of the study.

Table 5: Results of mean, standard deviation and sample sizes for the experimental and control groups on the Hyperactivity Scale of the Conners' Teacher Rating Scale-Revised.

Group	Mean	SD	N
Experimental	65.72	12.45	25
Control	64.70	10.01	26

As with the previous scales, the mean of the experimental and control groups shows a numerical difference. ANC∅VA was used to determine whether the resulting difference in means was statistically significant. The results of this analysis are shown in Table 6.

Table 6: Summary of Analysis of Covariance (ANC∅VA) comparison of the experimental and control groups on the Hyperactivity Scale of the Conners' Teacher Rating Scale-Revised.

Sources of Variation	Mean Square	df	F	P-Value
Experimental vs. Control	11.748	1	129.558	.765
Within Groups (error)	6218.785	48		
Total		**49**		

As shown by the data in Table 6, there was NOT a significant difference ($P<.05$) between the experimental and control groups change in the manifestation of behaviors from the beginning of the study.

Table 7: Results of mean, standard deviation and sample sizes for the experimental and control groups in the ADHD Index Scale of the Conners' Teacher Rating Scale-Revised.

Group	Mean	SD	N
Experimental	75.04	9.66	25
Control	68.42	10.92	26

There was a numerical difference in the means of the experimental and control group as shown in Table 7. Analysis of covariance was used to determine whether the resulting difference in means was statistically significant. The results of this analysis are shown in Table 8.

Table 8: Summary of Analysis of Covariance (ANC∅VA) comparison of the experimental and control groups on the ADHD Index Scale of the Conners' Teacher Rating Scale-Revised.

Source of Variation	Mean Square	df	F	P-Value
Experimental vs. Control	696.227	1	12.010	.001
Within Groups (error)	57.971	48		
Total		**49**		

As shown by the data in Table 8, there was a significant difference ($P<.05$) between the experimental and control groups' change in the manifestation of behaviors from the beginning of the study with the experimental group showing significant greater improvement. This variation can be attributed to Brief Solution Focus intervention initiated by teachers of the experimental group. Further results also indicate a significant correlation between the pretest and posttest scores as is required by the analysis of covariance.

Table 9: Frequency of Responses for Experimental and Control Groups on the Solution Identification Scale.

Groups	**Pretest**				**Posttest**			
Scales	NAA	JAL	PM	VM	NAA	JAL	PM	VM
Experimental (N = 26)	247	457	217	42	118	385	577	92
Control (N = 25)	272	317	246	57	192	369	282	59

(NAA = Not at all), (JAL = Just a little), (PM = Pretty much), (VM = Very much)

Teachers assessed each of the students on the Solution Identification Scale on 39 items related to behavior and attitude of students. The teachers rated on degree to which each item pertained to student's current behavior on a semantic differential scale ranging from NOT AT ALL to VERY MUCH. Then data was collected in an effort to determine whether intervention affected a greater shift in frequency of the less favorable to more favorable response for the experimental group than shift in the response frequency of the control group.

As shown in Table 9, the data suggests in the experimental group a combined frequency of 704 for pre-test responses NOT AT ALL and JUST A LITTLE. In the post-test, we observe a decline of frequency of 503 on the same two responses. The data for the experimental group suggests, in the pre-test responses for PRETTY MUCH and VERY MUCH, a combined frequency of 259. In the post-test, we observe an increase of frequency of 669 on the same two

responses. These results indicate a significant shift from less favorable student behaviors to more favorable student behaviors in the teachers' opinions.

Again, as shown in Table 9, the data of the control group suggests a combined frequency of 589 for pre-test responses NOT AL ALL and JUST A LITTLE. In the post-test, we observe a similar frequency of 561 on the same two responses. The data for the control group in the pre-test responses for PRETTY MUCH and VERY MUCH suggests a combined frequency of 303. In the post-test, we observe a similar frequency of 341 on the same two responses. These results indicate a minimal shift from less favorable student behaviors to more favorable student behaviors in the teachers' opinions. These variations appear to be attributed to effective Brief Solution Focused Therapy interventions initiated by teachers of the experimental groups in the opinion of the teachers.

In addition, the Teacher Assessment Form, given at the conclusion of the research experiment for the experimental group teachers to complete (see Appendix D, Table 10), was an indication of the outcome of those teachers opinion concerning the effectiveness of utilizing Brief Solution Focused Therapy interventions in the classroom. The data suggests higher frequency ratings, for each of the three scales, in favor of the effectiveness of the intervention strategies of Brief Solution Focused Therapy.

Chapter V

Discussion

The major purpose of this study was to determine the positive effects upon students of Brief Solution Focus Therapy interventions used by teachers in the classroom. This objective required teachers to learn about and implement strategies defined in the Brief Solution Focus Therapy model with pre-determined students in their classrooms.

Assessment Results

The results of the research were primarily found to be in support of the hypothesis purposed. This hypothesis stated that there will be a significant reduction in student's negative behaviors with the teachers who utilize solution-focused brief strategies with students as opposed to those teachers who do not utilize these interventions. With the first instrument of measurement used, the Conners' Behavior Rating Scale-Revised, significant statistical improvement was found on the two rating scales of Oppositional and ADHD. On the remaining two scales, Cognitive Problem/Inattention and ADD, positive changes did occur but not with statistical significance. On the second instrument, the Solution-Identification Scale, teachers were required to rate the degree in which each of the 39 items pertained to the student's current behavior on a semantic differential scale. Data were collected to determine whether interventions affected a greater shift in frequency of the less favorable responses to more favorable response for

the experimental groups than shift in the response frequency of the control group. Results indicated a significant shift from less favorable student behaviors to more favorable student behaviors in the opinion of the experimental teachers' group. The results of the control group data, however, indicated a minimal shift from less favorable student behaviors to more favorable student behaviors in the teachers' opinions. These differences in shifts appeared to have been attributed to effective Brief Solution Focus Therapy interventions initiated by the teachers of the experimental group. In addition, the Teacher Assessment Form, given at the conclusion of the research to the experimental group teachers to complete, was an indication of the outcome of those teachers' opinions concerning the effectiveness of using Brief Solution Focus Therapy interventions in the classroom. The data suggested higher frequency ratings for each of the three scales in favor of the effectiveness of the intervention strategies of Brief Solution Focus Therapy.

Previous studies conducted agree with results and findings of this research study. The following is a summary of those cited which lend support. Author Sheri Eisengart completed a review summary of all published outcome research on Brief Solution Focus Therapy up through 1998. The review covered fifteen controlled outcomes. The results of the review led the author to conclude that the box score analysis provided strong initial support for the effectiveness of Brief Solution Focus Therapy (Eisengart, 1998).

Metcalf and Durrant use the Brief Solution Focus Therapy approach with teachers, administrators and counselors in dealing with school populations. This approach, Brief Solution Focus Therapy, used by many private therapists and

counselors, is now being applied in schools with great success (Durrant, 1995; Metcalf, 1995).

Author Murphy supports Brief Solution Focus Therapy as a time-limited counseling format effective in resolving school problems. This has been further supported by a large body of researchers such as Budman and Gurman, Koss and Butcher, Kross and Shiang, Lubarsky, Singer and Lubarskym and Orlinsky and Howard, whose extensive research offers important clues as to why brief therapy works (Murphy, 1992).

In addition, authors Dielman and Franklin explain the benefits of Brief Solution Focus Therapy in helping youths diagnosed with ADHD. Adolescents with ADHD are more likely to have other behavioral diagnosis, such as oppositional defiant disorder or conduct disorder, as was supported by present research experiment as well. The authors concluded that Brief Solution Focus Therapy provides a positive-multi model approach and can be useful when working with adolescents with ADHD and their families.

Limitations

Limitations of the study, as stated previously, also include a scope of only one suburban middle-school in St. Charles county. Another foreseen limitation of the study was relying upon teacher perspectives of behavior problems and relying on them to administer the interventions. Attempts were made, however, to insure that teachers had successfully implemented the strategies by using the Teacher Assessment Survey. In addition, the possible bias of teachers in administering the testing instruments (CBR-S and SIS) more than once is noted. A final limitation

lay within the fact that, in dealing with the "behavioral sciences" the studies of human beings, the research potentially has to deal with more variables in the equation.

The main criticism of the group experimental design was a possible interaction between the pretest and the treatment, which may have made the results generalizable only to other pretested groups. The seriousness of this potential weakness depends on the type of pretest, the nature of treatment, and the length of the study. When this design is used, the researcher needs to evaluate and report the possibility of a pretest treatment interaction.

Recommendations

Two of the sub-scales of the Conners' Behavior Rating Scale-Revised did not adequately supported the purposed hypothesis of this study. While research did show improvement on the Cognitive Problems/Inattentive scale and Hyperactively scale, it was not a significant difference ($P<.05$) between the experimental and control groups change in the manifestation of behaviors from the beginning of the study. Additional studies and research are suggested to observe whether other methods may prove useful in addition to the application of the Brief Solution Focus Therapy model (i.e. medication). Also, future research should be broadened to include multiple agents, such as administrators and parents, within the studies. Future research may benefit from an increase in the length of time allowed for workshop participation and length of time allowed for the study itself.

Implications

The results of this research have provided additional support for the past studies reporting on the benefits of utilizing Brief Solution Focus Therapy interventions in school settings. By incorporating purposed recommendations in this study into the established guidelines described by previous researchers, counselors, educators and parents can work collaboratively together to establish a successful operation of a multi-model of Solution Focused-Brief Therapy in schools. It is throught the collaborative efforts of each of these dimensions involved in the child's life that the greatest strides toward successful implementation can be achieved. Therefore, this collaborative effort and reinforcement to one another, thereby, creating a balance across the entire sprectum in the life of a child.

Appendix A

Subjects of the Research Plan

In this study the sample was comprised of twenty-eight subjects who were divided into two groups. The first group of subjects were the experimental group with interventions. The second group, the control group, did not receive any interventions throughout the research process.

The subjects were drawn from the population of educators at the middle school level who had either a Bachelors or Masters degree in the educational field. The research sought volunteers from the same middle school building within a specified district in the county of St. Charles. The majority of participants were to be from an average socioeconomic status. The range of ages varied from twenty-five to fifty years of age. The sample predominantly consisted of a white, female population.

Volunteers were sought to form the pool of possible subjects. From this pool the subjects formed two equal groups - an experimental and a control group.

One source of sampling bias within this research plan was the fact that this study was limited to the population of teachers in one suburban middle school within a St. Charles County school district. As such, the majority of the sample was predominantly comprised of white, female subjects.

Appendix B

Conners' Teacher Rating Scale - Revised (S)

by C. Keith Conners, Ph.D.

Child's Name:_____ **Gender: M F**

Birthdate:____/____/____ (Month / Day / Year) **Age:**_____ **School Grade:**_____

Teacher's Name:_____ **Today's Date:**____/____/____ (Month / Day / Year)

Instructions: Below are a number of common problems that children have in school. Please rate each item according to how much of a problem it has been in the last month. For each item, ask yourself, "How much of a problem has this been in the last month?", and circle the best answer for each one. If none, not at all, seldom, or very infrequently, you would circle 0. If very much true, or it occurs very often or frequently, you would circle 3. You would circle 1 or 2 for ratings in between. Please respond to each item.

	NOT TRUE AT ALL (Never, Seldom)	JUST A LITTLE TRUE (Occasionally)	PRETTY MUCH TRUE (Often, Quite a Bit)	VERY MUCH TRUE (Very Often, Very Frequent)
1. Inattentive, easily distracted	0	1	2	3
2. Defiant	0	1	2	3
3. Restless in the "squirmy" sense	0	1	2	3
4. Forgets things he/she has already learned	0	1	2	3
5. Disturbs other children	0	1	2	3
6. Actively defies or refuses to comply with adults' requests	0	1	2	3
7. Is always "on the go" or acts as if driven by a motor	0	1	2	3
8. Poor in spelling	0	1	2	3
9. Cannot remain still	0	1	2	3
10. Spiteful or vindictive	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Fidgets with hands or feet or squirms in seat	0	1	2	3
13. Not reading up to par	0	1	2	3
14. Short attention span	0	1	2	3
15. Argues with adults	0	1	2	3
16. Only pays attention to things he/she is really interested in	0	1	2	3
17. Has difficulty waiting his/her turn	0	1	2	3
18. Lacks interest in schoolwork	0	1	2	3
19. Distractibility or attention span a problem	0	1	2	3
20. Temper outbursts; explosive, unpredictable behavior	0	1	2	3
21. Runs about or climbs excessively in situations where it is inappropriate	0	1	2	3
22. Poor in arithmetic	0	1	2	3
23. Interrupts or intrudes on others (e.g., butts into others' conversations or games)	0	1	2	3
24. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
25. Fails to finish things he/she starts	0	1	2	3
26. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand instructions)	0	1	2	3
27. Excitable, impulsive	0	1	2	3
28. Restless, always up and on the go	0	1	2	3

Conners' Teacher Rating Scale - Revised (S)

by C. Keith Conners, Ph.D.

Child's Name:_____ Gender: M F

Birthdate:_____/_____/_____ Age:_____ School Grade:_____
Month Day Year

Teacher's Name:_____ Today's Date:_____/_____/_____
Month Day Year

For each item, transfer the circled number into each of the white boxes across the row. Sum each column and write the totals in the boxes at the bottom.

A. Oppositional	B. Cognitive Problems/ Inattention	C. Hyperactivity	D. ADHD Index				
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
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				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				0	1	2	3
				TOTALS			

Scale Descriptions

A. Oppositional

Individuals scoring high on this scale are likely to break rules, have problems with persons in authority, and are more easily annoyed and angered than most individuals their own age.

B. Cognitive Problems/Inattention

High scorers may be inattentive. They may have more academic difficulties than most individuals their age, have problems organizing their work, have difficulty completing tasks or schoolwork, and appear to have trouble concentrating on tasks that require sustained mental effort.

C. Hyperactivity

High scorers have difficulty sitting still, feel more restless and impulsive than most individuals their age, and have the need to always be on the go.

D. Conners' ADHD Index

Identifies children/adolescents "at risk" for ADHD.

Profile for Males: Conners' Teacher Rating Scale - Revised (S)

Child's Name:_____ **Gender: M F** (Circle One)

Birthdate: ____/____/____ (Month / Day / Year) **Age:**_____ **School Grade:**_____

Teacher's Name:_____ **Today's Date:** ____/____/____ (Month / Day / Year)

A. Oppositional					B. Cognitive Problems/ Inattention					C. Hyperactivity					D. Conners' ADHD Index				
1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
.	.	13	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
13	11	.	.	8	.	.	.	.	11	.	.	.	.	14	.	.	.	36	29
.	.	.	12	.	10	.	.	.	.	.	.	.	18	.	.	.	.	35	28
.	.	12	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	34	.
12	.	.	.	.	.	.	.	.	.	.	.	.	17	13	.	.	.	33	27
.	10	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
.	.	.	11	7	9	.	.	15	10	.	.	.	.	.	.	.	.	32	26
.	.	11	.	.	.	.	.	.	.	.	.	21	16	12	.	.	.	31	25
11	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	30	.
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10	.	.	.	.	.	15	.	.	.	21	.	19	14	.	35	.	35	28	23
.	.	.	.	6	.	.	.	13	.	.	20	.	.	.	34	.	34	27	22
.	8	.	9	.	.	.	15	.	.	20	.	18	.	.	33	.	33	.	.
.	.	9	.	.	.	14	.	12	8	19	19	17	13	10	32	36	32	26	21
9	.	.	.	.	7	.	14	.	.	.	18	.	.	.	31	35	31	25	20
.	.	.	.	.	.	13	.	.	.	18	.	16	12	.	.	34	30	24	.
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8	.	.	.	.	.	.	.	.	7	17	.	15	.	.	29	32	28	23	.
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.	.	.	7	.	.	.	12	10	.	16	.	14	.	8	27	30	27	21	17
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7	.	.	.	.	.	.	11	.	.	.	14	13	.	.	25	28	25	.	16
.	.	.	.	4	5	.	.	9	6	14	.	.	.	7	24	27	24	19	.
.	.	6	6	.	.	10	10	.	.	.	13	12	9	.	23	26	23	18	15
6	5	.	.	.	.	.	.	8	.	13	.	.	.	.	22	25	22	17	14
.	.	.	.	.	.	9	.	.	.	12	12	11	8	6	21	24	21	.	.
.	.	.	5	.	4	.	9	.	5	.	.	.	.	.	20	23	20	16	13
.	.	5	.	3	.	.	.	7	.	11	11	10	7	.	19	22	19	15	12
5	4	.	.	.	.	8	8	.	.	.	10	.	.	5	18	21	18	14	.
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4	.	.	.	.	.	.	7	.	.	.	.	8	.	4	15	18	16	12	10
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.	.	.	3	2	.	6	6	5	.	.	.	7	.	.	13	16	14	.	.
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.	.	2	2	.	.	.	.	.	.	5	5	.	3	.	.	12	10	7	6
2	.	.	.	.	.	4	4	3	2	.	.	4	.	2	9	11	9	.	.
.	.	.	.	1	1	.	.	.	.	4	4	.	.	.	8	9-10	8	6	5
.	1	.	1	.	.	3	3	.	.	.	.	3	2	.	7	8	.	5	4
1	.	1	.	.	.	.	.	2	.	3	3	.	.	1	6	7	7	4	.
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Note:
For age-groups:

Column 1: ages 3 to 5

Column 2: ages 6 to 8

Column 3: ages 9 to 11

Column 4: ages 12 to 14

Column 5: ages 15 to 17

Please see back of scoring sheet for Scale Descriptions

Please see reverse for CTRS-R Female Profile

Profile for Females: Conners' Teacher Rating Scale - Revised (S)

Child's Name:_____ **Gender: M F** (Circle One)

Birthdate:____/____/____ (Month / Day / Year) **Age:**____ **School Grade:**____

Teacher's Name:_____ **Today's Date:**____/____/____ (Month / Day / Year)

	A. Oppositional					B. Cognitive Problems/ Inattention					C. Hyperactivity					D. Conners' ADHD Index				
T	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
90	.	.	8	10	5	.	.	.	14	10	.	.	.	.	.	.	.	.	27	.
89	.	.	.	.	.	.	.	15	.	.	.	.	11	.	.	19	31	25	.	14
88	.	.	.	.	.	.	.	.	.	.	11	15	.	.	.	.	30	.	26	.
87	.	7	.	.	.	.	.	.	.	.	.	.	.	11	.	.	.	24	.	.
86	.	.	.	.	.	.	.	14	13	9	.	.	.	.	.	18	29	.	25	13
85	.	.	7	9	.	.	15	.	.	.	.	14	10	.	.	.	28	23	24	.
84	4	.	.	.	.	5	.	.	.	.	10	.	.	.	.	17	.	22	.	.
83	.	.	.	.	.	.	.	13	12	.	.	13	.	10	.	.	27	.	23	12
82	.	.	.	.	4	.	14	.	.	.	.	.	.	.	.	.	26	21	.	.
81	.	6	.	8	.	.	.	.	.	8	.	.	9	.	.	16	.	.	22	.
80	.	.	.	.	.	.	.	12	11	.	9	12	.	.	.	.	25	20	21	11
79	.	.	6	.	.	.	13	.	.	.	.	.	.	9	.	15	24	.	.	.
78	.	.	.	.	.	.	.	.	.	.	.	.	8	.	2	.	.	19	20	.
77	.	.	.	.	.	4	12	11	10	7	.	11	.	.	.	.	23	.	.	10
76	.	5	.	7	.	.	.	.	.	.	8	.	.	8	.	14	22	18	19	.
75	3	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	17	18	.
74	.	.	5	.	.	.	11	10	9	.	.	10	7	.	.	13	21	.	.	.
73	.	.	.	.	3	.	.	.	.	.	.	.	.	.	.	.	20	16	17	9
72	.	.	.	6	.	.	.	.	.	6	7	.	.	7	.	.	19	.	.	.
71	.	.	.	.	.	.	10	9	.	.	.	9	.	.	.	12	.	15	16	.
70	.	4	.	.	.	.	.	.	8	.	.	.	6	.	.	.	18	.	15	8
69	.	.	.	.	.	3	.	.	.	.	.	.	.	.	.	11	17	14	.	.
68	.	.	4	5	.	.	9	8	.	5	.	8	.	6	.	.	.	.	14	.
67	.	.	.	.	.	.	.	.	7	.	6	.	.	.	.	.	16	13	.	7
66	.	.	.	.	.	.	8	.	.	.	.	.	5	.	.	10	15	12	13	.
65	2	.	.	.	.	.	.	7	.	.	.	7	.	.	.	.	.	.	12	.
64	.	3	.	.	2	.	.	.	6	.	.	.	.	5	.	9	14	11	.	6
63	.	.	3	4	.	.	7	.	.	4	5	6	.	.	.	.	13	.	11	.
62	.	.	.	.	.	2	.	6	.	.	.	.	4	.	1	8	.	10	.	.
61	.	.	.	.	.	.	.	.	5	.	.	.	.	4	.	.	12	.	10	.
60	.	.	.	.	.	.	6	.	.	.	.	5	.	.	.	.	11	9	9	5
59	.	.	.	3	.	.	.	5	.	.	4	.	.	.	.	7	.	.	.	.
58	.	2	.	.	.	.	.	.	.	3	.	.	3	.	.	.	10	8	8	.
57	.	.	2	.	.	.	5	.	4	.	.	4	.	3	.	6	9	7	.	4
56	1	.	.	.	.	.	.	4	.	.	.	.	.	.	.	.	8	.	7	.
55	.	.	.	2	1	1	4	.	.	.	3	.	.	.	.	.	.	6	6	.
54	.	.	.	.	.	.	.	.	3	2	.	3	2	.	.	5	7	.	.	3
53	.	1	.	.	.	.	.	3	.	.	.	.	.	2	.	.	6	5	5	.
52	.	.	1	.	.	.	3	.	.	.	.	.	.	.	.	4	.	.	.	.
51	.	.	.	.	.	.	.	.	2	.	2	2	.	.	.	.	5	4	4	2
50	.	.	.	1	.	.	.	2	.	.	.	.	1	.	.	.	4	.	3	.
49	.	.	.	.	.	.	2	.	.	1	.	.	.	1	.	3	.	3	.	.
48	.	.	.	.	.	.	.	.	1	.	.	1	.	.	.	.	3	.	2	1
47	.	0	0	.	.	0	.	1	.	.	1	.	.	.	.	2	2	2	.	.
46	0	.	.	0	0	.	1	.	.	.	.	.	0	0	0	.	.	1	1	.
45	.	.	.	.	.	.	.	.	.	0	.	0	.	.	.	.	1	.	0	.
44	.	.	.	.	.	.	0	0	0	.	.	.	.	.	.	1	0	0	.	0
43	.	.	.	.	.	.	.	.	.	.	0	.	.	.	.	.	.	.	.	.
42	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	0	.	.	.	.
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39	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
38	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.

Note:
For age-groups:

Column 1: ages 3 to 5

Column 2: ages 6 to 8

Column 3: ages 9 to 11

Column 4: ages 12 to 14

Column 5: ages 15 to 17

Please see back of scoring sheet for Scale Descriptions

Please see reverse for CTRS-R Male Profile

SOLUTION IDENTIFICATION SCALE (S–Id)

Name: ..... Date: ..... Rated by: .....

Please answer all questions. Beside each item, indicate the degree to which it occurs.

		Not at all	Just a little	Pretty much	Very much
1	Respectful to grown ups				
2	Able to make/keep friends				
3	Controls excitement				
4	Cooperates with ideas of others				
5	Demonstrates ability to learn				
6	Adapts to new situations				
7	Tells the truth				
8	Comfortable in new situations				
9	Well behaved for age				
10	Shows honesty				
11	Obeys adults				
12	Handles stress well				
13	Completes what is started				
14	Considerate to others				
15	Shows maturity for age				
16	Maintains attention				
17	Reacts with proper mood				
18	Follows basic rules				
19	Settles disagreements peacefully				
20	Gets along with brothers/sisters				
21	Copes with frustration				
22	Respects rights of others				
23	Basically is happy				
24	Shows good appetite				
25	Sleeps OK for age				
26	Feels part of the family				
27	Stands up for self				
28	Is physically healthy				
29	Can wait for attention/rewards				
30	Tolerates criticism well				
31	Can share the attention of adults				
32	Is accepted by peers				
33	Shows leadership				
34	Demonstrates a sense of fair play				
35	Copes with distractions				
36	Accepts blame for own mistakes				
37	Cooperates with adults				
38	Accepts praise well				
39	Able to "think" before acting				
40	COMMENTS :				

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SECONDARY SCREENING FORM

Student Behavior Rating Form

_____
Student's Name

TO THE TEACHER: Please evaluate this student on the following qualities by placing a check mark opposite the statement which most nearly describes the student's characteristics.

1. QUALITY OF WORK

- Over 50% of work is unacceptable ( )
- 25 50% of work is unacceptable ( )
- Less than 25% of work is acceptable ( )
- Work usually meets minimum standards ( )
- Work is of good quality ( )

2. QUANTITY OF WORK

- Wastes time ( )
- Production below class expectations ( )
- Meets minimum class standards ( )
- Produces more than required ( )

3. INITIATIVE

- Needs constant reminding ( )
- Works on his/her own but needs needs frequent checks ( )
- Needs average supervision ( )
- Applies self to task ( )
- Looks for things to do ( )

4. PERSISTENCE

- Works with difficulty ( )
- Stays on tasks but easily distracted & loses interest ( )
- Needs average supervision ( )
- Diligent to most tasks ( )
- Persistent regardless of circumstances ( )

5. ATTITUDE

- Antagonistic to tasks ( )
- Avoids tasks ( )
- Performs tasks without enthusiasm ( )
- Shows enthusiasm for some tasks ( )
- Usually enthusiastic for tasks ( )

6. APPEARANCE: DRESS & GROOMING

- Poor hygiene ( )
- Not suitable to school ( )
- Seldom suitable ( )
- Moderately suitable ( )
- Usually suitable to school ( )

7. ATTENDANCE

- Absent ____ days per week ( )
- Absent 5-6 days per month ( )
- Absent 3 4 days per month ( )
- Absent 1 day per month ( )
- Absent 1 by each 80 90 days ( )

8. ACCEPTANCE OF AUTHORITY

- Antagonistic ( )
- Violates rules occasionally ( )
- Accepts but needs occasional reminder ( )
- Knows and follows without reminder ( )
- Follows rules consistently ( )

9. HUMAN RELATIONS WITH PEERS

- Unable to work with peers ( )
- Able to work with only 1 2 peers ( )
- Usually no conflict with peers ( )
- Strives to work in small group ( )
- Works well in all peer groups ( )

10. SOCIAL SKILLS

- Is an Isolate ( )
- Has few friends ( )
- Social skills comparable to peer ( )
- Participates in social activities ( )

11. COMPREHENDING TASKS

- Does not understand directions ( )
- Slowly catches on ( )
- Usually understands ( )
- Needs only brief explanations ( )
- Grasps ideas quickly ( )

12. ABILITY TO REMEMBER INSTRUCTIONS

- Almost never remembers ( )
- Occasionally remembers simple instructions ( )
- Usually remembers 1 2 steps ( )
- Remembers 3 or more steps 75% of the time ( )
- Remembers most instructions most of time ( )

Signature _____ Date_____

Class_____

Appendix C

April 10, 2000

Dear Fellow Co-Workers:

In completing my masters in school counseling I am presently enrolled in a Research and Statistics course at Lindenwood University in which I am required to design, conduct and write about a research experiment.

I am in need of forty teacher volunteers to give a small amount of their time and effort to assist me in this endeavor.

It would require three basic steps: fill out a 2-page questionnaire pretest; implement easy solution-focused techniques for 4 weeks with students; and fill out the 2-page follow-up questionnaire posttest.

I would supply all necessary materials and instructions. There will be a brief 5 minute meeting after school one day at your convenience to answer any questions you might have.

Your assistance would be tremendously appreciated! Please let me know by checking the appropriate squares and returning the attached form indicating your decision. If you feel you can help me out, please read and sign the attached permission form and return it to me along with your answer page.

Thank you so very, very much!! I will immediately follow up with a flyer announcing the dates for a very brief meeting in the near future.

Thank you again, so very much.

Karen Boyle
MC6

Name: _____

Room Number: _____

I <u>can</u> help with your study. ☐

I <u>cannot</u> at this time. ☐

I am able to attend a brief meeting:

Before school ☐

After school ☐

Please return no later than Wednesday, April 12.

Thank you

Karen Boyle - MC6

I understand the nature of the research experiment being conducted by Karen Boyle through Lindenwood University. I understand all data and information will be kept confidential from all others besides myself, the researcher and the instructor. I agree to participate in the above described research experiment.

Name: _____ **(Please Print)**

Signature: _____ **Date:** _____

INTERVENTION TO BRING ABOUT CHANGE

Reframing (altering how the problem is viewed)

- for the student - a new view of the situation may lead to different behavior
- for the teacher - a new view of the situation may lead to different responses

Pattern Interruption (altering the "doing" of the problem)

- introduce a (small) change into the habitual sequence of events that surrounds the problem
- small changes lead to bigger changes
- a deliberate small change brings an otherwise "unconscious" habit into conscious control

Observational Tasks

- Look out for those times that you are successful/that things go well/that you do something different
- Yields information about success that can be built on and orients the client towards success

Practicing (or continuing) Success

- Do more of what works - building on exceptions or presession change
- Practicing small steps that are part of the solution picture

Pretend Tasks

- Act "as if" the miracle/solution/goal has been achieved
- Allows clients to behave differently, others to look for difference, and adds an element of fun

Do Something Different

- Introduce an element of unpredictability
- When all else fails, do something different

Appendix D

Table 10: Frequency of response on the Teacher Assessment Form for the teachers in the experimental group.

1) Did you utilize the Student Information sheets with each student and discuss it with them in a brief follow-up meeting?

Groups	Yes	No
Experimental	6	7

2) Did you process the process the Student Success Diary and did you use it?

Groups	Yes	No
Experimental	5	8

3) Did you participate in the Brief Solution Focused Workshop and understand the format presented for intervention strategies to be used?

Groups	NVW	FW	VW
Experimental	0	2	11

4) On a scale of one to ten (one being the least and ten being the most) how well do you feel you were able to utilize the suggested intervention strategies of B.S.F.T.?

Rating	1	2	3	4	5	6	7	8	9	10
Frequency	0	0	0	0	1	2	2	4	4	0

5) On a scale of one to ten (one being the least and ten being the most) how would you rate the positive behavioral progress of your student(s) over the past four weeks?

Rating	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Frequency	0	0	0	1	0	2	2	8	0	0

6) How effective do you think the B.S.F.T. can be utilized in the classroom with one being non-effective and ten being very effective?

Rating	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Frequency	0	0	0	0	0	1	2	5	2	4

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