

Solution-Focused Brief Therapy Groupwork With At-Risk Junior High School Students: Enhancing the Bottom Line

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Despite the preliminary studies that support solution-focused brief therapy, limited research has examined the model as a group intervention with students at risk for academic underachievement and school nonattendance. Therefore, the purpose of this study was to evaluate the impact of the model on school attendance and grade point average. Solution-focused brief therapy was evaluated through a quasi-experimental pretest-posttest comparison group design in which 26 students receiving the intervention were compared to 26 students who did not. Compared to students who did not receive the intervention, students in the treatment group increased their grade point average from pretreatment to posttreatment. Conversely, no differences were found between the two groups on attendance. Solution-focused brief therapy shows promise as a group intervention with at-risk students. Moreover, the findings suggest the continued support of the model during a time in which K-12 education emphasizes accountability, hard data, and the bottom line.

Keywords: *solution-focused brief therapy; at risk; groupwork; school failure*

Academic underachievement and student nonattendance are two of the most current and compelling issues facing elementary and secondary public education. Recent estimates of academic performance have found that only 25% to 30% of students in fourth and eighth grade are performing at or above proficiency in reading and math achievement (National Center for Education Statistics, 2000, 2003). In addition, studies have found that almost 10% of all middle and junior high school students fail at least one subject each year (U.S. Department of Education [USDOE], 1990). Along with the issue of academic underachievement, principals across the United States report student nonattendance as a major concern in K-12, public education (National Center for Education Statistics, 1998). Studies have found that approximately 33% of students are absent each day in urban elementary and secondary schools (Gullatt & Lemoine, 1997; Strykowski, Anderson-Butcher, Green, & Brennan, 2001). Such

approximations are important given that school nonattendance, and academic underachievement are foremost related to school failure (Lamdin, 1996; Peterson & Colangelo, 1996), school dropout (Dynarski & Gleason, 1999; McCaughlin & Vachu, 1992), crime and violent offenses (Garry, 1996), and other problem behaviors (Jones, 1996; USDOE, 1996).

A common approach to address the issue of academic underachievement and student nonattendance in K-12 education is through the use of incentive programs, after-school enrichment activities, tutorial programs, individual counseling, active communication with parents and/or guardians, and by providing supportive services in the community (Chapman & Sawyer, 2001; Ford & Sutphen, 1996; Schinke, Cole, & Poulin, 2000). Another service modality for addressing this important issue is through the use of school-based groupwork. Groups allow for the development of mutual aid and support with similar others while also providing an opportunity for shared learning. School-based groupwork also makes efficient use of services offered by practitioners in school settings, who have multiple demands on their time.

A contemporary model that has gained popularity as a group intervention in school settings is solution-focused brief therapy (SFBT). As such, the use of SFBT has uncovered some promising results as a group intervention with Hispanic children of incarcerated parents (Springer, Lynch, & Rubin, 2000); students who exhibit

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bullying behavior (Banks, 1999); adolescent girls who have experienced childhood sexual abuse and been diagnosed with depression, oppositional defiant disorder, and posttraumatic stress disorder (Kruczek & Vitanza, 1999); and as a social skills group designed to enhance self-esteem (Lafountain, Garner, & Eliason, 1996). Likewise, SFBT has gained popularity in addressing the emotional and behavioral needs of prepubertal and pubertal adolescents (Franklin, Biever, Moore, Clemons, & Scamardo, 2001), as a brief counseling intervention for students with learning disabilities (Thompson & Littrell, 1998), and addressing the overrepresentation of African American boys in special education (Watkins & Kurtz, 2001).

Despite the promising results of SFBT, limited empirical research supports the model as an effective group intervention with students identified at risk for school nonattendance and academic underachievement. As such, the current study seeks to address an important gap in the literature. Specifically, the current study seeks to answer the following questions: (a) Will SFBT enhance the grade point average (GPA) of at-risk junior high school students when compared to at-risk junior high school students who do not receive SFBT? and (b) Will SFBT enhance the attendance levels of at-risk junior high school students when compared to at-risk junior high school students who do not receive SFBT?

SFBT IN GROUP SETTINGS

Many have asserted the use of SFBT as a way to help create new meanings, perceptions, and solutions with group participants (Coe & Zimpfer, 1996; LaFountain & Garner, 1996; LaFountain, Garner, & Eliason, 1996). Group practitioners using SFBT look to emphasize what individual members are already doing well, or have the potential to do well, as a way to facilitate goal achievement among all group participants (Banks, 1999; LaFountain, Garner, & Eliason, 1996; Selekman, 1999; Vaughn, Hastings-Guerrero, & Kassner, 1996).

To achieve such proactive change, practitioners of SFBT structure group sessions in a way that (a) utilize the resources and strengths presented by individual group members; (b) recognize that change, particularly positive change, by individuals is inevitable; (c) focus on a present and future orientation; (d) develop treatment sessions that are cooperative and collaborative; (e) point out that problems are not solved, however solutions are considered; (g) discuss exceptions to problems that then become the building blocks for solutions; and (h) organize treatment sessions that are goal directed and goal driven (Berg,

1994; Lafountain & Garner, 1996; LaFountain, Garner, & Eliason, 1996). From a practice standpoint, client potential is discovered through the use of purposeful language and questioning. Since the model's inception, SFBT practitioners in various settings with various clients readily assert the importance of language, dialogue, and questions as a way to help build and uncover strengths in clients (Corcoran, 1998; Fish, 1997; Franklin et al., 2001; Geil, 1998; Greene, Lee, Mentzer, Pinnel, & Niles, 1998; Kral, 1995; Metcalf, 1995; Thompson & Littrell, 1998). Indeed, de Shazer (1994), in his clinical trials of SFBT, found that purposeful, goal-oriented questions resulted in client recognition of possible solutions. Proclaiming that the use of purposeful questioning encourages clients to reinterpret their options in life while also providing them with an opportunity to assess their own future (de Shazer, 1994).

To provide options for the future, questions such as the miracle question, scaling question, relationship question, and the exception-finding question are commonly used by SFBT practitioners. For example, the SFBT practitioner using the miracle question might ask the following:

Suppose that tonight, while you are asleep, there is a miracle and the problem that brought you here today has been solved. However, because you were asleep you were unaware that this miracle happened. Could you tell me, what would be different in the morning that would tell you a miracle has taken place?

In addition, the practitioner might also ask the scaling question, "On a scale from 1 to 10, with 1 being least confident, and 10 being most confident, where on this scale would you say you are now, and where on the scale would you like to be?" Additional techniques include the relationship question, "Who would notice that you had reached your goal on the scale. If a close friend were here right now, what would he or she say about how you have reached this goal? What would she or he be seeing that would convince her or him that you had accomplished this goal?" And finally the exception-finding question: "Tell me when the issue that brought you here today was less of a problem." Such questions help to coconstruct a future without the problem, empower the client to recognize his or her own strengths, and facilitate client change (Greene et al., 1998).

Whether in individual or group settings, the intention of the aforementioned questions are used to better understand the individual's feelings and aspirations while also conveying a sense of past successes and future accomplishments. The use of such purposeful and goal-oriented questions in group practice conveys to all its participants a meaning of being "stuck" and not "sick," and the

likelihood of “change” instead of “stagnation” (Davis & Osborn, 2000). Therefore, emphasis in SFBT group practice is no longer aligned with dysfunction and pathology but rather placed in a context that focuses on impending possibilities. As pointed out by Coe & Zimpfer (1996), “Group members are viewed as resources who can assist each other in identifying situations in which the problem is not present or when the goal has been met successfully” (p. 49).

METHOD

Research Design

The use of a quasi-experimental pretest-posttest comparison group design was used to examine the differences between students who received SFBT and students who did not on the dependent variables of GPA and Attendance. The research design employed the use of multiple group leaders with varying degrees of SFBT experience to help control for treatment outcomes that might be attributable to individual qualities and leadership styles. Participants in the intervention group as well as the comparison group consisted of the same participant pool. Placement of students in the intervention group was based on each student’s class schedule, the grade of the student, and the likelihood that SFBT would not interfere with the student’s academic classes (i.e., math, English, social studies, history, etc.). Conversely, the aforementioned factors were not considered for students who did not receive SFBT given that they were used for comparison purposes only. Given the age of the study population, it was necessary to gain parental consent as well as informed consent from the study participants. In keeping with university requirements, The Ohio State University’s Human Subjects Committee approved all study procedures for the requirement of human participants.

Sample Procedure

A nonprobability, convenient sample was used in the study. Participants for the study were selected from the current seventh- and eighth-grade roster from the participating Central, Ohio, junior high school. Similar to other schools in the area, the student body of the junior high school consisted of a diverse, middle-class population. Potential participants for the study were defined as “Any student in the seventh and/or eighth grade identified as being at risk for academic failure based on below-average academic performance and/or displaying chronic and/or

low attendance from the previous academic year who was not receiving or currently under the provisions of an Individual Education Plan (IEP).”

In identifying participants for the study, a list of 90 students deemed at risk for academic underachievement and school nonattendance was compiled by the assistant principal and two school counselors. Outlines and letters, which explained the study in full detail, were mailed to the parents of the 90 potential students. Each letter provided parents with an overview of SFBT, the length of the study, the intervention focus (i.e., GPA and attendance levels) and a request for their participation.

Preparation and Training of SFBT Group Leaders

To ensure the treatment of SFBT, two MSW II graduate students, the author (who at the time of the study was a doctoral candidate), and the existing school social worker at the participating junior high school, completed an 8-week course on the application of SFBT. To provide consistency to each of the trainees, a syllabus was designed and followed over the 8-week period. Training consisted of lecture material, reading assignments, videotapes, and role-playing using the SFBT model. Preparation and training of group leaders was cofacilitated by the author and the author’s doctoral adviser.

The Application of SFBT

Each of the group facilitators met with their respective SFBT group for the equivalent of one class period (i.e., 35 min) for 8 weeks. To ensure the application of the SFBT model, the author developed a SFBT protocol that was reviewed before each session by the group facilitators. SFBT group facilitators met 1 hr preceding each treatment session to discuss the focus of the groups as outlined by the SFBT protocol. To monitor the use of SFBT, tape recordings of Treatment Sessions 2 through 7 were conducted by the author, the two MSW II interns, and the school social worker. The content covered in each of the SFBT groups is listed next:

Session 1. Introductions. Obtained informed consent for participation. Discussed group expectations. Discussed the goals of the group (i.e., to increase academic competency, classroom conduct, homework completion, and attendance levels).

Session 2. In-session assignment. “What academic/school goals do you have this semester?” and “What do

you hope to achieve by participating in this group for the next 8 weeks?" Use of the miracle question.

Session 3. Use of the scaling question (i.e., "On a scale from 1 to 10, with 1 being your academic/school goals not achieved and 10, your academic/school goals completely achieved, where would you rate yourself as a student today"?). Homework assignment for next week: "Where would you like to be on the scale at the end of the semester and provide the group with ways you will accomplish this increase?" (Goal and future oriented).

Session 4. Review Session 3 homework assignment. Group discussion on "signs of success" in achieving academic/school goals. Homework assignment for next week: First, "If I asked Mr./Ms. _____, your _____ teacher how he or she had witnessed these signs of success in your academic/school goals, what do you think he or she would say?" (i.e., the relationship question). Second, please write down your signs of success in which you came closer to reaching your end of the semester score on the 1-to-10 scale.

Session 5. Review Session 4 homework assignment. Use the solution-focused brief therapy technique: EARS (i.e., elicit, amplify, reinforce, and start over). Use of the exception-finding question to amplify and reinforce present and future change.

Session 6. Revisit the scaling question. Homework assignment: A letter from the "older, wiser self" (Dolan, 1995). "Imagine that you have grown to be a healthy, wise old man or woman and you are looking back on this period of your life. What would this older and wiser man or woman suggest to you, which helped you get to where you are now in your academic/school goal(s)."

Session 7. Review Session 6 homework assignment. Discuss how the "new" self has emerged: Employ EARS. Homework assignment: "A letter from the future."

Session 8. Review Session 7 homework assignment. Discuss setbacks as being normal. Pass out certificates of success.

Outcome Measures

The outcome measures for the study were the nonintrusive measures of GPA and student attendance. At the participating junior high school, students were graded on an A-to-E scale in which A = 4.00, B = 3.00, C = 2.00,

D = 1.00, and E = 0.00. Student attendance data was the numerical count of days absent from the school. To limit the influence of a particularly difficult or easy marking period, GPA and absences were averaged for the three marking periods prior to the intervention. A similar average was also computed for the marking period when the intervention took place and the two marking periods following the intervention. As a result, pre-GPA and preabsences were made up of the first three marking periods (i.e., marking periods 1, 2, and 3) before the onset of SFBT treatment while post-GPA and postabsences was made up of the last three marking periods (i.e., marking periods 4, 5, and 6), during the academic school year.

RESULTS AND DATA ANALYSIS

Univariate and multivariate statistical analysis was used to examine the differences between participants in the intervention and comparison groups on the dependent variables of GPA and Absences. Measures of central tendency, independent *t* tests, chi-square, and ANCOVA were used as statistical techniques in the study. As with other applied outcome research, the .05 level of statistical significance was used in the study.

At the onset of the study, a total of 28 students had agreed to participate in SFBT treatment. However, 2 of the 28 students participating in the treatment group moved from the school district during Week 3 and Week 5 of treatment. Therefore, the total number of students in the intervention group was 26, 13 in seventh grade and 13 in the eighth grade. Similarly, the comparison group contained a total of 26 students, 13 in the seventh grade and 13 in the eighth grade (see Table 1 for sample description). Differences between the intervention group and comparison group were examined through χ^2 and *t* tests. Based on the analysis, students in the intervention and comparison groups were found to be similar according to these descriptive variables.

With the intervention and comparison groups sufficiently similar, univariate analysis was used to examine the pretest and posttest GPA of students participating in the study. As Table 2 illustrates, the mean for students receiving SFBT treatment at pretest was 1.58 (*SD* = .64), whereas the mean at posttest was 1.69 (*SD* = .64). For the comparison group, the mean at pretest was 1.66 (*SD* = .67), whereas the mean at posttest was 1.48 (*SD* = .74).

To examine the differences between the intervention and comparison groups on the dependent variable of GPA, pre-GPA was used as a covariate in the analysis. To test the appropriateness of using pre-GPA as a covariate, a

TABLE 1: Description of Sample (N = 52)

Characteristic	Treatment Group N (%)	Comparison Group N (%)	Total N (%)
Grade			
Seventh	13 (25)	13 (25)	26 (50)
Eighth	13 (25)	13 (25)	26 (50)
Total	26 (50)	26 (50)	52 (100)
Gender			
Male	19 (36.5)	19 (36.5)	38 (73)
Female	7 (13.5)	7 (13.5)	14 (27)
Total	26 (50)	26 (50)	52 (100)
Ethnicity			
White	21 (40.3)	16 (30.8)	37 (71.1)
African American	5 (9.7)	8 (15.4)	13 (25.1)
Mexican American		1 (1.9)	1 (1.9)
Asian American		1 (1.9)	1 (1.9)
Total	26 (50)	26 (50)	52 (100)

TABLE 2: Means and Standard deviations of Pre-GPA and Post-GPA as a Function of Group and Time

Source: GPA	Treatment Group (N = 26)		Comparison Group (N = 26)	
	M	SD	M	SD
Pre-GPA	1.58	.64	1.66	.67
Post-GPA	1.69	.64	1.48	.74

NOTE: GPA = grade point average.

sequence of steps took place. More important, the results of each step determined the appropriateness of assessing SFBT on the dependent variable of post-GPA for students in the treatment group as well as the comparison group.

Using ordinary least squares regression, postintervention GPA was regressed on a dummy variable denoting membership in the intervention or comparison group. To account for preintervention differences in GPA, this analysis also included preintervention GPA as a covariate. A critical assumption of using the preintervention GPA in this manner is that no group by covariate interaction exists (Cohen, Cohen, West, & Aiken, 2003). Such a relationship would violate the requirement of a common regression posttreatment GPA on the dummy variable for group membership, the pre-GPA covariate, and a variable representing the group by covariate interaction. With the sequence of steps applied, the interaction term was found not significant ($B = .338$, $SE B = .206$, $t = 1.64$, $p = .107$), supporting the appropriateness of using preintervention GPA as a covariate.

Given that the interaction was not significant, the next step was to test the difference between those students who participated in the treatment group to those students in the comparison group. As a result, analysis found that

TABLE 3: Regression Coefficient Table (GPA)

Variable	B	SE B	β	t	R ²
Constant	-.074	.194	-.373	ns	
Preintervention GPA	.934	.104	.781	8.942	.592
Tx. and Comp. Group	.293	.135	.189	2.163*	.627

NOTE: GPA = grade point average; ns = not significant. Dependent variable: post-GPA.

* $p < .05$.

participants in the treatment group had enhanced their post-GPA relative to the comparison group when using pre-GPA as the covariate, $F(2, 49) = 41.24$, $p < .05$. However, as can be seen in Table 3, the proportion of variance explained (R^2) is not large. Thus, raising questions concerning how critical SFBT was in effecting change on GPA.

As with the dependent variable of GPA, initial univariate analysis examined the dependent variable of absences of those students participating in the intervention and comparison groups. Table 4 illustrates that for students receiving SFBT treatment, the mean at pretest was 1.58 ($SD = .64$), whereas the mean at posttest was 1.69 ($SD = .81$). For the comparison group, the mean at pretest was 1.66 ($SD = .67$), whereas the mean at posttest was 1.48 ($SD = .74$).

Once again, to compare and assess the differences between the intervention and comparison groups on the dependent variable of absences, preabsences was used as a covariate. Following the same sequence of steps applied to the dependent variable of GPA, postintervention absences was regressed on a dummy variable denoting membership in the intervention or comparison group. To

TABLE 4: Means and Standard Deviations of Preabsences and Postabsences as a Function of Group and Time

Source: GPA	Treatment Group (N = 26)		Group (N = 26)	
	M	SD	M	SD
Preabsences	1.58	.64	1.66	.67
Postabsences	1.69	.81	1.48	.74

NOTE: GPA = grade point average.

TABLE 5: Regression Coefficient Table (Absences)

Variable	B	SE B	β	t	R ²
Constant	1.418	.349	4.063	ns	
Preintervention Absences	.475	.143	.426	3.322	.189
Tx. and Comp. Group	-.301	.379	-.102	-.794*	.200

NOTE: Dependent variable: postabsences; ns = not significant.
* $p > .05$.

account for preintervention differences on absences, this analysis also included preintervention absences as a covariate. However, analysis of the possible interaction of pretreatment absences on the dependent variable of posttreatment absences uncovered that the interaction was statistically significant, ($B = .233$, $SE B = .109$, $t = 3.04$; $p = .04$), therefore not supporting the appropriateness of using preintervention absences as a covariate. As can be seen in Table 5, no statistical significance was found between the participants in the intervention and comparison group on the dependent variable of absences, $F(2, 49) = 4.62$, $p > .05$.

DISCUSSION AND APPLICATIONS TO SCHOOL WORK PRACTICE

Previous research on SFBT has demonstrated moderate levels of success with K-12 populations (Franklin et al., 2001; Thompson & Littrell, 1998; Watkins & Kurtz, 2001). Research also has demonstrated the effectiveness of SFBT as a group intervention designed to enhance peer relationships, self-esteem, and ways of coping with emotions (Banks, 1999; LaFountain & Garner, 1996; LaFountain, Garner, & Boldosser, 1995; LaFountain, Garner, & Eliason, 1996). The results of the current study indicate that SFBT may possess some qualities as a group intervention with students at risk for academic underachievement. As described in the current

study, group participants who received SFBT enhanced their overall GPA from pre- to postintervention. Equally important to these gains is that the content covered in the SFBT groups recognized each of the participant's own strengths and potential in provoking and sustaining their academic ability.

Despite the encouraging results pertaining to GPA, no statistical significance was found between the two groups on the dependent variable of school attendance. A closer look at the data, however, points to an important issue when considering the possible impact of SFBT on postattendance levels. Participants in the treatment group did not present an issue of school attendance at the beginning of the school year, or at the onset, duration, or conclusion of the study. In fact, participants in the study appeared to be attending school on a regular basis. Thus, student nonattendance may have been an issue for the participants in their previous academic school year—a criteria for meeting the at-risk definition as well as participation in the study—but appeared to be an irrelevant issue during the academic school year when the study took place. This, in turn, may have resulted in the lack of treatment outcomes on this dependent variable. On the other hand, a stabilization of attendance by the participants receiving the SFBT intervention is very encouraging.

However, precautions are warranted in generalizing the results of the current study to other K-12 populations who are at risk for academic underachievement and school nonattendance. In particular, the current study has a number of internal validity threats that must be considered. First, an argument could be made that greater gains for the treatment group in the current study may be explained or due to selection rather than SFBT treatment. As a result, the findings from the current study are subject to possible selection bias given that only participants in the study whose parents provided consent were included in the study sample. In addition, one must recognize that change from pre-GPA to post-GPA may be due to factors associated with maturation. This is especially true of junior high school students who may change developmentally, socially, or in other ways because of their experience at the beginning of the school year to the end of the school year. Second, one must consider that treatment outcomes may be attributable to extraneous variables not controlled for in the study. Events such as parent-teacher school conferences, after-school detention, and/or behavioral plans initiated by teachers and/or parents are important components to consider when assessing the impact of a treatment intervention designed to enhance academic or attendance change during the school year.

With the aforementioned considerations, future studies must begin to compare the potential impact of SFBT with other types of treatment that address academic failure and school nonattendance. Such studies also must monitor the meetings, or supportive counseling sessions students may have with school counselors, school psychologists, and treatment providers in the community to fully assess and evaluate the gains that are attributable to any "one" intervention. Future studies should also look at maintenance and change over time as well as the extent to which change in academic areas occur from one school year to the next and from primary education to secondary education. Last, not every participant participating in an applied, outcome research project may be ready to change simply because treatment is made available. One must recognize that even when support services in schools are offered, adolescents may refuse treatment or be slow to change. In such instances, treatment gains may be measured in more modest terms, not by radical shifts in GPA or attendance levels but rather by a willingness to participate in treatment, the openness to change, and the initiation of the self-evaluative process.

Despite the limitations and future research considerations, SFBT does appear to be a group treatment model that might aid social workers in school settings who are working with students at risk for academic underachievement and student nonattendance. Along these same lines, the findings suggest the continued support of SFBT during a period of time in which K-12, public education emphasizes accountability, hard data, and the bottom line. With such considerations, the findings highlight the importance of improving student performance while also addressing the needs asserted by school administrators and school stakeholders. However, researchers and practitioners must continue to investigate SFBT and its appropriateness as a group intervention in school settings. It is through the continued assessment and evaluation of SFBT that the modality may develop into an effective group approach utilized by social workers in K-12 settings.

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