Solution-Focused Family Therapy With Three Aggressive and Oppositional-Acting Children: An N=1 Empirical Study

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The efficacy of Solution-Focused Family Therapy (SFFT) for helping three families with aggressive and oppositional-acting children (aged 8-9) was examined. The N=1 multiple-baseline design with three replications used validated measures, a treatment manual, and a treatment integrity measure. The interventions lasted from four to five sessions. SFFT appeared to be effective with the families at post-treatment and 3-month follow up.

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THERAPISTS NEED EFFICIENT, effective interventions for aggressive-acting children because of our high number of referrals and the pressure for quick results. More importantly, we need to prevent the tragic trajectory that carries aggressive children into the more tragic problems of criminal behavior in later life (Loeber, 1990; Patterson, Crosby, & Vuchinich, 1992) and substance abuse (Moffitt, 1993).

Solution-Focused Family Therapy (SFFT) offers the advantages of being a brief, strength-based therapy (DeJong & Berg, 1998; de Shazer, 1985). The approach focuses, not on the problematic behaviors or their causes, but on further developing the solutions the individuals already perform. The solutions/strengths are identified by focusing on the interactions or contexts when the problematic behaviors are not occurring. The brevity of therapy is accomplished by avoiding resistance through focusing on the positive goals (what should be increased) rather than the deficiencies. Brevity is also achieved by capitalizing on what the family does well already, thereby

avoiding the need to teach entirely new skills. Meeting for approximately six sessions (Lee, 1997; Zimmerman, Jacobsen, Macintyre, & Watson, 1996; Zimmerman, Prest, & Wetzel, 1997) has been found to substantially decrease dropout rates (Beyebach & Carranza, 1997).

There is a great deal of support and enthusiasm for SFFT in the literature (Eakes, Walsh, Markowski, et al., 1997; Lee, 1997; Zimmerman et al., 1996, 1997). A concern with the existent research is that the studies almost universally rely on unvalidated measures to judge outcome and do not have treatment integrity/adherence measures or clear descriptions of the presenting problems or functioning level. The initial studies, however, point toward the merit of further investigation into the efficacy of SFFT.

This study is a carefully controlled study of the efficacy of SFFT using two validated outcome measures, a treatment manual, and a treatment adherence measure. We hypothesized that Solution-Focused Family Therapy would reduce the aggressive, noncompliant behaviors of oppositional-acting elementary-aged children. Aggressive, noncompliant behavior was measured in two ways: a daily checklist of problem behaviors and a standardized measure of the child's emotional and behavioral well-being.

METHOD

Participant Families

The families were not charged for service in return for their participation. The first four families to respond were used as participants. All of the children were diagnosed consistent with *DSM-IV* Oppositional Defiant Disorder based upon the parental reports and had at least one clinical elevation on the global measure (see Table 1). Two children were taking medication and reporting diagnoses of ADHD. The children were between ages 8-9. None of the families reported a history of physical abuse of the child or chemical abuse in the current family. The family members were European-American. The family descriptions use pseudonyms. The use of medication was not viewed as problematic to the treatment. The medication did not change during treatment.

Therapists

The three therapists were doctoral students in Counseling Psychology who had six months of classes and role playing in Solution-focused Family Therapy. Two of the therapists had at least nine months of supervised application of Solution-focused Family Therapy. One of the therapists was female and two were male.

Measures

PDR The Parent Daily Report (PDR) is a 33-item checklist for daily rating of a child's misbehavior by the parent (Chamberlain & Reid, 1987; Patterson, 1974; Reid & Patterson 1976). Medium to strong reliability coefficients are reported (Chamberlain & Reid, 1987; Patterson, 1973). Concurrent validity was strong (Chamberlain & Reid, 1987; Chamberlain & Reid, 1991; Forgatch & Toobert, 1979).

BASC The Behavior Assessment System for Children—Parent Rating Scale (BASC) (Reynolds & Kamphaus, 1992) is a 130-item, multidimensional measure of children's adaptive and problem behaviors that is rated by parents. The BASC yields 12 subscale scores and four composite scale scores. The BASC has demonstrated satisfactory reliability, and concurrent and discriminative validity with previous samples (Reynolds & Kamphaus, 1992).

Procedure

Each family participated in an intake session in which they were interviewed, filled out forms, and began the Parent Daily Report (PDR), which was filled out

TABLE 1

The t-scores of the BASC[1] Parent Evaluations of their Children at Pre-treatment, Post-treatment, and Follow Up (FU)

	Tim			Arnie		Jon			Mary[4]		
Clinical Scales[2]	**Pre**	**Post**	**FU**	**Pre**	**Post**	**Pre**	**Post**	**FU**	**Pre**	**Post**	**FU**
Hyperactivity	84	90	84	55	50	79	74	71	48	40	62
Aggression	64	64	53	68	47	74	62	60	73	60	63
Conduct Problems	57	50	50	74	60	54	64	47	56	56	51
Anxiety	65	61	57	51	43	70	61	67	50	46	46
Depression	64	72	54	57	49	92	69	74	65	54	56
Somatization	53	53	58	39	47	39	47	44	38	35	35
Atypicality	84	67	72	42	46	55	63	59	41	46	50
Withdrawal	73	62	69	38	49	45	45	49	58	49	40
Attention Problems	81	78	78	61	61	66	68	68	65	55	63
Mean	69	66	64	54	50	64	61	60	55	49	52
Adaptive Scales[3]											
Adaptability	42	42	45	59	56	25	36	33	32	35	30
Social Skills	34	40	40	48	38	27	37	41	44	44	36
Leadership	54	56	58	43	48	28	39	37	47	40	42
Mean	43	46	48	50	47	27	37	37	41	40	36
Composite Scales											
Externalizing[2]	71	71	64	68	53	72	69	61	60	52	60
Internalizing[2]	64	66	58	49	45	72	62	65	51	44	44
Behavior Symptom[2]	84	82	73	58	49	82	73	74	60	50	60
Adaptive Skills[3]	42	45	47	50	47	23	35	35	40	38	34

[1] The 90% confidence interval of the BASC is +/−5. A change of 5 points has a 90% probability of being a non-chance occurrence.

[2] Clinical scale and the first three Composite scales *t*-scores of 70 or above are in the clinical range.

[3] Adaptive scale *t*-scores and Composite Adaptive Skills of 30 or less are in the clinical range.

[4] Mary was not included in the study because she reacted to the baseline measure. Her data is included to stimulate hypotheses and future studies.

every day until one week after the last session. No therapy was provided for the first two weeks in order to establish a baseline level for the PDR.

Family therapy was administered following the format for SFFT outlined in *Interviewing for Solutions* (DeJong & Berg, 1998). An author-devised checklist of required interventions and techniques was completed during each session by the observers and after each session by the therapist to insure treatment integrity (see Appendix for checklist). Each session was rated as containing the required components of SFFT. For the data analysis, treatment began when the family members became customers (DeJong & Berg, 1998). The family was considered a customer when each member agreed upon a goal that they could pursue.

A team of observers, including an experienced psychologist and at least one doctoral student, performed live supervision during each session. If the supervision team believed the therapist needed direction, the therapist was asked to meet with the team. The therapist could also initiate consultation at any time. Families reported being comfortable with the format. Each family received therapy until the therapist and the family verbally agreed that the family's goals had been reached and that therapy would no longer be needed.

The parents completed the PDR daily and were contacted by telephone twice

weekly to prompt compliance. No sessions were cancelled or missed. A member of the supervision team interviewed each family, once at one week after termination and the second time at three months after termination to obtain information about the family's experience in therapy and to re-administer the BASC. One family moved out of the area and could not be contacted for follow up information.

Research Design

A multiple-baseline design was used to determine whether change occurred. The intrasubject design allows for establishing whether an individual family changes by examining the temporal unfolding of the changes, but it does not allow for comparing one family to another (Hilliard, 1993). Multiple-baseline design overcomes the problems of history and maturation that confound case studies through continuous sampling (controlling maturation), and staggering the beginning treatment for each of the families (controlling history). Viewing a more continuous flow of the assessment allows us to judge whether the change happened when it was supposed to happen.

There is a limitation of having three families—we cannot be certain that the findings will generalize to other families. The strength of this design is that it allows for a more careful, conservative evaluation of a treatment.

Statistical Data Analysis

The method used to assess pretreatment (pre-customer) and treatment (customer) differences was a regression technique recommended by single-case investigators (Allison & Gorman, 1993; Faith, Allison, & Gorman, 1996; Parker & Brossart, in press) which has as its output an R^2. The Allison mean model compares mean differences between pre-treatment and treatment phases.

Results

The results section presents each family's analysis. The first family, Tim's family, presents greater detail as an example of the Solution-Focused Family Therapy process.

Tim's Family

Tim (age nine) attended 5 sessions over seven weeks with his mother and father (both age 51). He took medication for a diagnosis of ADHD. Tim's parents reported that he was argumentative, nonobedient, and had frequent, angry outbursts both at home and school. He had poor social skills and fought at school. They also reported that Tim collected and organized garbage and would not throw anything away.

Tim's first session is described in greater detail to communicate the processes used. The first session began with socializing and joining activities. Then the family members communicate the problems. The therapist is attentive but does not ask many follow up questions. In SFFT, the problems are not leading to health.

The problem-description phase upset Tim. He angrily disputed the negative reports of his parents and accused them (particularly his father) of screaming at him and throwing away his objects.

The therapist did not ask any person to admit any shortcomings, nor were there many follow up questions asked about problems. The therapist was concerned and respectful to each person's problem descriptions. The therapist allowed each person time for a brief presentation of their perception of the problems.

About 15 minutes into the session, the therapist began to ask about goals. The initial goals for Tim were general in nature: increased self-esteem, reduced anger, and increased responsibility. The therapist suggested that they begin with

a small, specific goal. After entertaining several goals, the parents decided that remedying the nightly issue about Tim getting out of the shower would greatly improve their evenings.

While the shower goal could seem insubstantial, the shower goal was acceptable because it was an observable, probably obtainable, positively stated goal. Most importantly, the parents perceived the shower goal as a step toward their larger goals. They affirmatively answered the question, "So how is Tim cooperating about the shower an indication that he is moving toward the larger goals of increased self-esteem, reduced anger, and increased responsibility?" As part of the solution orientation, the therapist uses the one-down or Columbo approach to encourage the family to trace the positive trajectory.

While Tim's mother and father were willing to work on a solution for the shower goal, Tim was not willing to commit to the goal of leaving the shower clean of objects and peacefully after 30 minutes. The therapist mentally noted Tim's misgivings but did not verbally focus on his hesitation. The therapist proceeded with the goal even though Tim's parents were considered customers while Tim was not a customer because he was not agreeing with the stated goal.

The therapist asked for reports from the family of when the last time Tim "took responsibility" (parents phrase) for getting out of the shower. This is an example of using the technique of finding exceptions to the problem process (DeJong & Berg, 1998). The family could not remember Tim ever responding adequately. However, there were behaviors approximating cooperation in other contexts when the mother used frequent, positive prompts. The therapist focused upon the positive reports by asking the family members many questions about the interactions. Tim was engaged in the systemic solution by asking him if he knew his mother was proud of his cooperative reactions. Then the father and mother were further engaged in understanding their systemic influence by asking Tim how he could tell when his parents were proud of him. This relational questioning leads the family to understand how they can cooperate in supportive interactions toward their goals.

After setting up the goal and possible solutions, the therapist then asked the miracle question (DeJong & Berg, 1998). "I have an interesting question for all of you. It is called a miracle question. Do you know what a miracle is? Yes, something that you wish for and poof, it happens. Say this miracle happens tonight, while you are asleep. This miracle happens. But you are asleep so you do not know that it happens. It changes everything that we have talked about. Tim you are really enjoying being responsible. Your parents are saying thanks and are very thrilled with the miracle. Everything has changed for the better. But the miracle happens while everyone is asleep so nobody knows it really happened. What is the first thing that you notice that lets you know that this miracle has occurred when you wake up in the morning?"

The discussion continues with a description of an enjoyable morning with everyone interacting positively. The therapist supports the positive affect while asking questions about why it would be enjoyable and elicits exact descriptions of the interaction.

The therapist then asks the first of two scaling questions. Imagine a ruler where zero is not willing to work to make the miracle happen, and 10 is willing to work very hard. Tim says he is a one or two, mother says 9 and father says 8. The therapist responds that everyone is willing to work some on the goal.

The second scaling question was a ruler with zero as not hopeful and 10 is very

hopeful that this miracle is going to happen. Tim says 8, mother and father report a 10. The therapist compliments the family for their high confidence.

After a therapy break, the therapist delivers the parting statement that consists of complimenting the members of the family individually for their willingness to come to counseling and their desire to make the family better. Then the therapist reviewed the shower goals and linked how each person will be moving toward their larger stated goal through achieving the shower goal.

During the second session, the family was considered a customer because all three family members agreed on the goal and voiced interest in changing. The second session goal was doing homework without arguing or complaining. At the third session report, the homework goals were met and there was generally less arguing and complaining. Also, Tim reported that his parents behaved better, thus showing progress in their goals of reminding, encouraging, and praising him.

Beyond the session goals, the parents noted that Tim asked for flashcards to help him learn and was generally more motivated. Tim also decreased his gathering of objects and began to throw some of the previously gathered objects away. He was reported as helping around the house, and the school noted that his reading level was improving. The third session goal was to complete spelling worksheets without complaining and for his parents to show pride in him. At the fourth session, Tim's parents reported that they received a positive note from school regarding his behavior, Tim was happier, cleaned-up more, and completed homework independently. The fourth session goal was to maintain or increase positive interactions in family. At the fifth session, Tim brought an award from school announcing his achievement in reading and science. Tim's parents reported less frequent arguments with Tim and that Tim negotiated well when disagreements happened.

Throughout the sessions, the parents' goal was to improve their reminding, encouraging, and praising behaviors. Tim reported their continuous improvement. Counseling was terminated by mutual decision at the fifth session. At the exit interview a week after the fifth session, the family members reported reaching their goals and being satisfied with the family therapy. Tim voiced the only concern. He worried that his dad may not continue his new positive behavior.

At the three-month, follow up the parents and Tim reported that things were continuing to go well. The parents reported that their relationship with Tim had continued to improve.

BASC As shown in Table 1, four of Tim's BASC subscale scores were in the clinical range before treatment, while three were in the clinical range one week after treatment and at the three-month follow up. Tim's scores on all four composite scales indicated no change from pre- to post-treatment, with all composite scores showing improvement at the three-month follow up.

The BASC results suggest that there was focused improvement only through the time period of therapy. The specific improvement in subscale scores at post-treatment was in the atypicality, withdrawal, and social skills. However, the depression subscale worsened at post-treatment (an issue denied by the parents when they were directly asked about it). There was improvement in all of the composite scales and the depression subscale at the three-month follow up. Statistical improvement is claimed because the change of BASC scores from pre-treatment to follow up improved 5 or more points (i.e., the 90% confidence interval). (We can be 90% confident that the

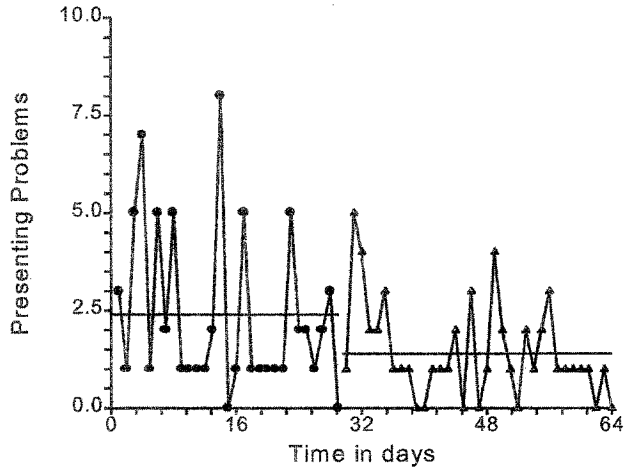

FIG. 1. Tim's frequency of presenting problems reported on the Parent Daily Report for each day. The first horizontal line represents the mean of the noncustomer or pre-treatment phase. The second horizontal line represents the mean of the customer or treatment phase.

changes were not due to chance. This is the benefit of using a normed instrument such as the BASC.) Clinical significance is claimed when the scores move below 70, which removes them from the clinically anomalous range.

PDR The graph of the PDR scores for Tim presented in Figure 1 visually suggests that the second phase (the customer or treatment phase) was lower in problematic behaviors than was the first phase (the pre-customer or pre-treatment phase). Results from the ALLISON-M technique corroborate the visual impression that Tim's family improved (R^2 = .35).

Arnie's Family

Arnie (age nine) attended therapy with his mother (age 42). Arnie's mother reported that he often fights with his siblings, and that his teachers sent home negative reports weekly, describing Arnie as talking back, throwing tantrums, throwing objects, getting angry, lying, and not listening to directions. Arnie and his mother agreed that the goal of therapy was to help Arnie have fewer outbursts and become less argumentative at home.

Arnie's father (age 45) was employed as a truck driver and was frequently away from home during the week. Arnie's parents had four other children, two boys (age 6 and 18) and two girls (age 13 and 15). Both Arnie and his six-year-old brother were originally foster-children, and were adopted as infants. Arnie's six-year-old brother had a serious physical disability.

Arnie's family met with their therapist for five sessions over seven weeks. Arnie's family was considered a customer during their second session, which was four weeks after beginning their data collecting. After therapy, his mother reported that Arnie argued less frequently with his siblings and was better able to talk things out when he became angry or frustrated. Arnie stated that he was more able to enjoy the time that he spent with his mother. No follow up data (BASC or interview) was collected for Arnie since he and his family moved during the follow up period and could not be contacted.

BASC Arnie's BASC results are presented in Table 1. As shown, the conduct subscale of the BASC was in the clinical range before treatment (74) but moved

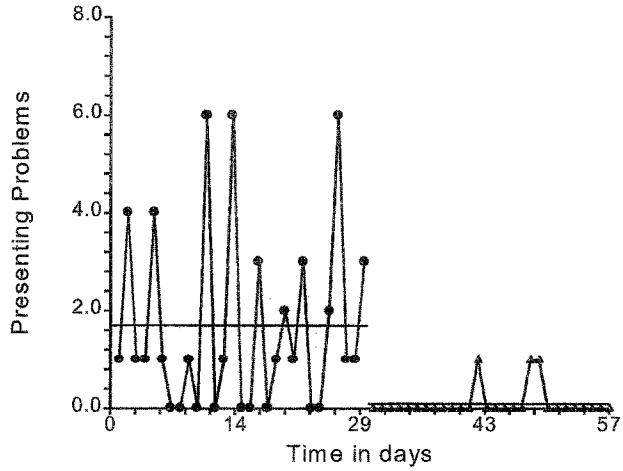

FIG. 2. Arnie's frequency of presenting problems reported on the Parent Daily Report for each day. The first horizontal line represents the mean of the noncustomer or pre-treatment phase. The second horizontal line represents the mean of the customer or treatment phase.

out of the clinical range one week after treatment (60). This is a 14 point change, much greater than the 5 points required for the 90% confidence interval. At post-treatment, there was improvement in the following subscales: hyperactivity, aggression, conduct problems, anxiety, depression, and leadership skills. There was deterioration in the subscales of somatization, withdrawal, and social skills. The deterioration noted did not move the scores outside the normative range.

Arnie's composite scores of externalizing had a statistically significant improvement (from 68 to 52, a change of 16 points) as did his behavior symptom composite scores (from 58 to 49, a change of 11 points). The externalizing composite score moved from the at-risk range during the pre-treatment phase to the average range at post-treatment. The BASC results suggest that there was statistically significant improvement through the time period of therapy because they changed more than the 5 points required for 90% certainty.

PDR The graph of the PDR scores for Arnie, presented in Figure 2, visually suggests that the noncustomer or pre-treatment period was volatile, with scores varying greatly. Results from the ALLISON-M technique corroborate the visual impression that Arnie's family improved (R^2 = .27). During the customer phase, the problem frequency neared zero.

Jon's Family

Jon (age eight) attended therapy with his biological mother (age 29) and his stepfather (age 30). The family reported a diagnosis of ADHD, for which Jon took medication daily. His parents described him as not following directions and often rude and oppositional. Jon and his family stated that, as a result of therapy, they hoped that Jon's acting-out behavior at home would decrease and that his parents would be better able to interact with Jon in a calm, pleasant manner.

Jon attended some classes for children with learning disabilities, in which he received consistently good grades. Both parents had been in a previous marriage and together had one male child, age 3, who did not attend the sessions. Jon's mother reported growing up in an abusive family

with a chronically depressed, alcoholic father. She also reported that her first husband (Jon's biological father who sees him regularly) was alcoholic and abusive toward her. Jon and his family met with their therapist for four sessions over a seven-week period. Jon's family was considered a customer during their second session, which was four weeks after beginning their data collecting. Jon's parents reported that his behavior improved steadily throughout the course of therapy. After the first session, Jon reported having one "good day" a week and stated that he wanted to increase this number. From the second session on, Jon continued to set goals for himself, and the frequency of his "good days" increased to five a week by the end of therapy. Jon and his parents reported that the parents were better able to speak calmly to Jon, and remind him how much they appreciate his cooperation with the family.

At the three-month follow up, Jon's mother reported that Jon's behavior was not as good as it was at the end of therapy. She attributed the problems to increased contact with Jon's biological father and requested further therapy to deal with that issue.

BASC As shown in Table 1, seven subscales of the BASC were in the clinical range before treatment while only one was in the clinical range one week after treatment and two at the three-month follow up. At follow up, there was statistically significant improvement in the following subscales: Hyperactivity (down from 79 to 71), Aggression (down from 74 to 60), Conduct Problems (down from 54 to 47), and Depression (down from 92 to 74). There was significant improvement in two of the desirable adaptive scales: Adaptability (increased from 25 to 33) and Social Skills (increased from 37 to 44). All of the subscale improvements were evident at follow up except for the Anxiety subscale. From pre- to post-treatment, there was deterioration in the subscales of Conduct Problems, Somatization, and Atypicality. Conduct Problems and Somatization were improved at follow up.

Jon's composite scores had statistically significant improvement from pre-treatment to follow up on Externalizing (from 72 to 61), Internalizing (from 72 to 65), Behavior Symptoms (73 to 60), and Adaptive Skills (improved from 23 to 35). The composite scores showed improvement at follow up that was out of the clinically problematic range.

PDR The graph of the PDR scores for Jon presented in Figure 3 visually suggests that the customer period was lower in problematic behaviors than was the pre-customer period. Results from the ALLISON-M technique corroborate the visual impression that Jon's family improved (R^2 = .46).

DISCUSSION

Three cases supported the hypothesis that Solution-Focused Family Therapy would benefit children who were oppositional and aggressive. Evidence from the Parents' Daily Report of problematic behavior, the BASC, and the verbal reports of the clients, teachers, and therapist all indicated that Tim, Arnie, and Jon benefited from Solution-Focused Family Therapy. At the end of four or five sessions, the families believed that the concerns that brought them to family therapy had been resolved.

Mary's case study did not meet the requirements for inclusion in the study. The family reacted to the baseline dependent variable (PDR) in such a way that the hypothesis examining SFFT was not possible. That is, the family reported changing when they began recording Mary's daily negative behaviors that were displayed on the refrigerator. The parents stated that the PDR provided a helpful

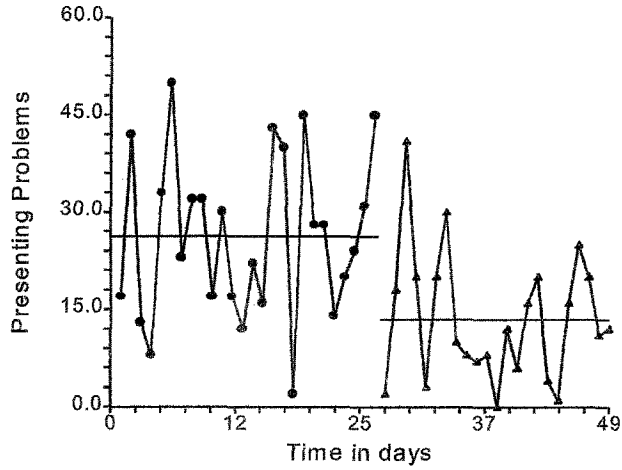

FIG. 3. Jon's frequency of presenting problems reported on the Parent Daily Report for each day. The first horizontal line represents the mean of the noncustomer or pre-treatment phase. The second horizontal line represents the mean of the customer or treatment phase.

guideline for inappropriate behavior that they could use with their daughter.

Mary's case study is interesting because Mary had the most deterioration of scores on the BASC at the three-month follow up when compared to the other three cases (Table 1). Additionally, Mary's family was the only family that evidenced an increase in problematic behavior on the PDR (Figure 4). Both the deteriorating PDR scores and the follow up BASC scores indicated that the helpful change due to monitoring deteriorates over time. This finding raises some interesting issues that require further research. Future research could examine the possibility that the act of monitoring negative behavior is more difficult to

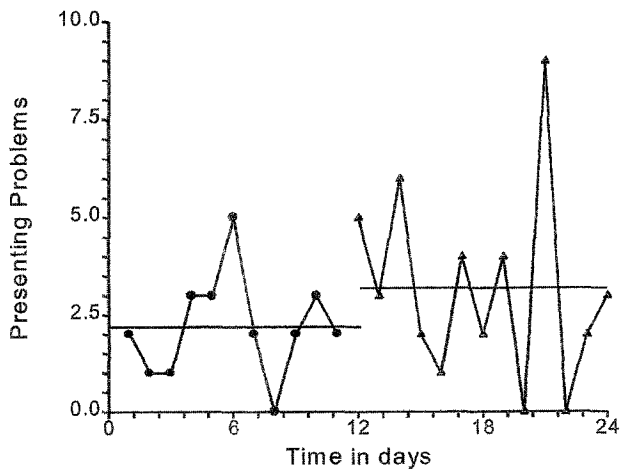

FIG. 4. Mary's frequency of presenting problems reported on the Parent Daily Report for the baseline, meeting phase, and one week after termination. The first horizontal line represents the mean of the phase before the first session. The second horizontal line represents the mean of the series after the first session. This family never became customers.

maintain than the positive interactions established by using approaches such as SFFT. That is, the monitoring of negative behavior is aversive to everyone involved in the process, resulting in a lack of inherent support for the process. A different explanation is that monitoring of the negative behavior was maintained but its helpfulness diminished.

Only one family wanted more family therapy when contacted at follow up. The desire for further service was for a different problem (i.e., dealing with an ex-husband/biological father). Not requesting further services for dealing with problems in aggression, and anecdotal evidence of improvement in school were viewed as further support for the effectiveness of SFFT.

An interesting finding was the generalization or escalation of changes that occurred in the children. The application of SFFT requires the family to focus upon small, specific behaviors that are viewed as problematic but are large enough that if the problem decreased, the family would evaluate the change as progress toward a larger goal (DeJong & Berg, 1998). In meeting a few specific goals that were focused upon in therapy, larger changes were evident in the BASC scales and the verbal reports of the family.

For example, the specific goals for Tim were for him to get out of the shower when asked, do homework without arguing or complaining, and complete spelling worksheets without complaining. The goals of increasing Tim's compliance and reducing his complaining and arguing should be reflected on Tim's BASC externalization composite score. What was surprising was improvement in all of the BASC composite scores at follow up. Tim's internalizing, behavior symptoms, and adaptive skills all improved. Tim's parents also mentioned specific changes that indicated changes beyond the stated goals. The parents mentioned a decrease in his compulsion of collecting objects, his willingness to throw away some of his objects, and his appearing happier. None of these issues were ever spoken about except at the first session during the time when the parents listed their concerns.

There are several limitations of this study. The problem-oriented daily measure may have interfered with the effectiveness of SFFT. The use of a problem-oriented measure required the families to focus on the problematic behavior every day which was opposed to the techniques and philosophy of the solution-oriented approach (DeJong & Berg, 1998). The requirement of focusing on the negative behavior may have inhibited change, which would mean that this study provides conservative results of the treatment.

Another limitation is the small sample size. While the research substantiates that Solution-Focused Family Therapy was effective for three families, this was a small sample of available families. How SFFT will work with other families that are different from the three families included in this study cannot be known with certainty. Future research on families with different characteristics is required.

Finally, the supervision model used in this study was a live, interactive model. Live supervision allowed us to control the process of the therapy so that it met the requirements of SFFT. However, the live supervision limits the generalizability of the study because it is not the manner in which SFFT is generally used in the field.

In summary, this study used a treatment manual, a treatment integrity measure, and validated measures. The three families receiving therapy demonstrated that Solution-Focused Family Therapy can be effective in working with elementary-aged children with problems in aggressive and oppositional behavior (consistent with *DSM-IV* Oppositional Defiant Disorder). Furthermore, at three-month follow up, the changes were still

apparent and had generalized to other areas of the child's functioning. Future research needs to replicate these results.

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APPENDIX

Solution-Focused Family Therapy Checklist

The following must be included in the initial session; titles with an asterisk must be included in subsequent sessions.

Socializing and Joining (Explore each person's activities, resources, strengths. Ending with, "How can I help today?")

Problem Description ("How is this a problem for you?" "How have you dealt with it?" "Was that helpful?")

Goal Negotiation* ("What could happen today to look back on and say I am glad we came for counseling?" Identify specific, small goals. Goals are the presence, not absence, of positive behavior. "How would that be helpful? What would be different?")

Presence of Positive Behavior* ("What will he/she be doing *exactly* that would let you know change is occurring?" "If there is a sign that says that today will be a good day, what would that look like?")

Relationship Question* (Weaving significant others into interactional questions. "Is that what you want too?" "How would that be helpful to you?" "How can he/she help you?" "How can you tell your parent likes it when you . . .?" "What would your _____ notice different about you tomorrow morning? Does your _____ know how much you care about them?")

Miracle Question (Gather information until common family goals can be weaved together before performing Miracle Question. Follow Miracle Question with many questions that concretely describe what everyone would do in reaction to and contributing toward the miracle. "What PART of the miracle can really happen?")

Exception Finding* (Exception finding is discovering a past behavior that was an exception to the problem behavior [i.e., a solution]. This can be inquired about throughout the session. "When was the last time something like that [a solution] happened?" "Is that something that could happen again? If so, what makes you think so?" "Tell me all about it.")

Small Goal* ("What small goal should we choose to accomplish between now and our next meeting?" A positive behavior, not an absence of negative behavior; Followed by relationship questions and exception finding questions.

Scaling Questions* (Using a ruler simile to measure attitudes to gauge progress from past sessions and to formulate a next small step toward the larger solution. Each person is asked to respond.)

a. "On a scale 1-10, a 10 being willing to work really hard to change and 1 representing not caring at all, where are you?" "What would it take to go from an n to a n+1? What exactly will have to happen?"
b. "On a scale 1-10, a 10 being very hopeful that things will be better and 1 representing no confidence at all? Where are you?" "Where do you want to be?" "What would it take to go from an n to an n+1? What exactly will have to happen?"

Restate Concrete Goal* ("So this is what you are looking for?" Restate the client's goal.

"Now how would that be helpful?" "What can he/she do to make it easier?")

* **Five-minute break** to construct ending.

Ending* Contains:

a) Compliments- (Compliment the individuals' content and feelings. Appreciate their efforts.)

b) Bridging Statement- (Acknowledge that each person's concern is important and interrelates. Build a justification for the task that follows.)
c) Task (If concrete and detailed goals are established and the family is a customer then: "In next week pick one day and pretend miracle happens and notice all the differences." If *not concrete*: "Think about what is happening in your life that tells you this can be solved. And I'll do some thinking too." If an influential member of the family is a complainant then the task is, "Notice the positive differences that happen between now and the next time we meet." If an influential member of the family is a visitor then the task is, "Think about what could be solved or changed to make life better for you."

The subsequent sessions begin with identifying what has changed for the better and do not necessarily follow up on tasks unless brought up by the family. Success and growth is the focus.