

Brief Solution-Focused Therapy with Parents and Adolescents with ADHD

According to DSM-IV (American Psychiatric Association, 1994) criteria, students with attention-deficit hyperactivity disorder (ADHD) have significant problems in sustained attention and concentration or problems with excessive activity, restlessness, and impulsiveness. Increasing demands for responsibility characteristic of the adolescent stage become problematic for the student with ADHD. Adolescents with ADHD usually have experienced a history of failures in academic performance, in addition to marked difficulties in social relationships. Psychologically, these adolescents may be more likely to struggle with poor self-concept, depression, diminished hopes of future success, and concerns about school completion (Barkley, 1990; Flick, 1996). Consequently, adolescents with ADHD often associate with peers who have similar problems, and as a result engage in more risk-taking behaviors (Flick, 1996).

Adolescents with ADHD are more likely to have other behavioral diagnoses, such as oppositional defiant disorder or conduct disorder. In academics they have difficulty managing tasks that require planning for long-term projects, developing study habits, organizing activities, manag-

ing varying class schedules, and balancing social life with school demands. Adolescents with ADHD may become easily bored with schoolwork, rushing through their work with little consideration for neatness, accuracy, or assignment completion (Parker, 1994). Furthermore, they may have trouble negotiating the various demands of the middle school and secondary school structure, including the greater number of teachers, the short duration of class periods, the more frequent changes in class schedules, and the heavier emphasis on self-control, individual organization, and responsibility for completing assignments. These difficulties are likely to result in a dramatic drop in educational performance and often bring adolescents with ADHD to the attention of school social workers and other professionals (Barkley, 1990). This Practice Highlight discusses the use of a brief, solution-focused family intervention for working with adolescents with ADHD. A case example with an ADHD adolescent and his parents illustrates how the model can be used in a school setting.

Effective Practice Approaches

Research indicates that a multimodal intervention approach is essential for

the management of adolescents with ADHD in a school setting. In a review of the research literature on effective treatments for ADHD, Estrada and Pinsof (1995) noted that the use of psychostimulant medication is supported. However, the use of relatively short-term medication does not necessarily lead to long-term improvement. The use of long-term combined treatments, on the other hand, may have more lasting effects. Strategies such as family education about ADHD, academic intervention, individual counseling, groupwork, and family sessions are important for helping adolescent students with ADHD (Barkley, 1990; Flick, 1996; Parker, 1994).

The involvement of parents in this process is essential to the progress of the ADHD student in school and other settings (Barkley, 1990; Barkley, Guevremont, Anastopoulos, & Fletcher, 1992; Ziegler & Holden, 1988). Estrada and Pinsof (1995) noted that, even though family interventions alone were not effective in reducing inattention, impulsiveness, and overactivity (core symptoms of ADHD), family interventions were effective in reducing children's non-compliance and aggression, and management of these characteristics is likely to have a positive effect in a school setting. Barkley et al. (1992) also suggested that family treatments using problem-solving and communication training focus on positive attributions made by family members and healthy aspects of family functioning, not just family conflicts and negative attributions by family members. The brief, solution-focused therapy provides a positive, multimodal approach and can be useful when working with adolescents with ADHD and their families.

Solution-Focused Therapy Model

The solution-focused therapy model originated with deShazer (1985, 1988, 1991, 1994), Berg (1994), Miller (Berg & Miller, 1992), and their colleagues (deShazer et al., 1986) at the Brief Family Therapy Center in Milwaukee, Wisconsin. This model emphasizes the coconstruction of solutions from conversations between a school social worker and the client (Berg & DeJong, 1996). Coconstruction emerges as a result of the school social worker's careful and skillful questioning to facilitate the client's recognition of prior successes and solutions (exceptions to the problem) as well as visualizations of future solutions ("miracle question").

The solution-focused therapy model also provides specific types of questioning techniques that help clients think about behavior changes. The "miracle question" is perhaps the best known of these questioning techniques (Berg, 1994; deShazer, 1988), and an example of it follows:

Let's suppose that you leave here today and you go home. You do your regular routine (describe some aspects of evening routine interactively with the client) and then you go to sleep. While you are sleeping, a miracle happens, but you do not know it because you are sleeping. And the miracle is this—all the problems you were talking about with me today are solved (describe the problems as they have been discussed by the client). When you wake up, what will you notice that is different that will tell you that while you were sleeping a miracle happened?

Cade and O'Hanlon (1993) emphasized that people need to describe the presence, not the absence, of

behaviors, attitudes, and feelings in the discussion of the miracle question. It is more productive for clients to imagine the presence of behaviors, attitudes, and feelings rather than their absence. School social workers using this approach encourage miracle pictures of specific, observable behaviors, which can be more easily reproduced than feelings and attitudes.

Another question is used to measure how severely clients rate the current problem on a scale of 1 to 10 (scaling question), with 1 being the problem at its worst and 10 being the problem resolved. With the scaling question clients can be asked what they did to increase the number from the past and what they will do to increase the number slightly in the future. In the scaling question the school social worker asks where the client sees her- or himself or others on a scale of 1 to 10, where 1 represents the worst time and 10 represents the time after the miracle. When clients report higher numbers, the reasons for more success in solving the problem can be explored. Also, clients can be asked what the circumstances would be like if they were slightly higher on the scale (.5 to 1 point higher). The scaling question can be used to evaluate progress toward a solution, severity of a problem, and the client's confidence in finding a solution, motivation to work on a problem, level of self-esteem, as well as the client's ability to set priorities among problems to be solved, and the likelihood of hurting the self or another person (Berg, 1994; DeJong & Berg, 1997).

Clients are viewed as possessing competencies and are asked what they have done to handle difficult situations (coping question). During the second and future sessions, clients are

asked "What's better?" With the school social worker's help, clients are able to explore what they did that was helpful. While seeking therapy for problems, clients tend to see the problem as constant and tend to dismiss as trivial the times when the problem was less severe. As deShazer (1991) suggested: "These exceptions are not seen by the client as differences that make a difference" (p. 58). Cade and O'Hanlon (1993) noted that, once these exceptions are recognized as successful, clients can be encouraged to build on what they are already doing. Often clients can talk more readily about these exceptions after being asked the miracle question. One of the benefits of the miracle question is that it helps clients explore and cognitively rehearse imagined attitudinal and behavioral differences in themselves and others.

It is important for clients to notice what differences in behavior will be seen, because ultimately only clients can change themselves. The miracle question, however, spawns related questions, such as what differences parents, teachers, siblings, and friends will notice in the client's behavior and attitude when the miracle happens. Once others notice this difference, how will they behave differently in response? An interactive exchange produces an elaborate and detailed picture of how people and relationships can be behaviorally and attitudinally different. A case example of this model with an adolescent with ADHD and his parents will be helpful in illustrating the uses of this model in a school setting.

Case Example

Nathan was a very bright seventh grader who was tall and lanky and had

one or two friends. He also ran cross country. He lived with his mother and stepfather. Nathan was referred to a school social worker because he was extremely aggressive, easily angered and frustrated, self-effacing, and very negative. He also showed little tolerance of others, was quite judgmental, and frequently cried for no apparent reason. He was on the medication Ritalin, which helped with some of this inattention and impulsiveness but did not completely alleviate aggressive behaviors. Nathan was also asthmatic and had to use an inhaler. Because of the severity of Nathan's aggressive behavior problems, the school social worker called the parents in for a counseling session at the school. Halfway through the first session, which only his mother attended, Nathan and his mother were asked the miracle question. Here are their responses:

Nathan: People would be nice to me and respect me.

School social worker: How will you be different when people are nice to you and respect you?

Nathan: I will be more respectful of them.

School social worker: What else will be different when this miracle happens?

Nathan: I will be able to control my attitude and temper.... I wouldn't be morphing between my baby voice and normal voice.

School social worker: What else?

Nathan: I would have greater upper-body strength and gain 10 to 20 pounds. My handwriting would be legible.

School social worker: What else?

Nathan: I would not be so fidgety.

School social worker: What will your mother notice differently

about you when you are not so fidgety? What would she see?

Nathan: I would be more calm and relaxed.

School social worker: And your teacher, what would she see?

Nathan: Uh, I would sit still more and not talk so much to Joey. Pete would leave me alone and I would not hit him.

School social worker: Hmm! What would you be doing instead of talking to Joey and hitting Pete?

Nathan: Uh ... I don't know ... [Silence]

School social worker: Think about it.... What would you be doing instead? [Pause, waiting expectantly for response]

Nathan: I would not be talking.... I would be opening my book and doing my work and asking the teacher for help. I might have to ask for the instructions again because I forget easy. I would not sit by Joey or Pete because they get me in trouble. Yeah, I would be sitting alone doing my work I guess.

School social worker: That's different?

Nathan: Yeah.

School social worker: That's good. You've indicated at least five or six things you would notice will be different when the miracle happens. [Turning to Nathan's mother] What will you notice different about Nathan when this miracle happens?

Mom: He'd be more relaxed. He'd have fewer mood changes and not be so down.

School social worker: How will he be different when he has fewer mood changes and is not so down?

Mom: He'd be more himself. He'd be more positive, not so negative and nasty when dealing

with conflict. He'd be more upbeat, not so down on himself.

Therapist: What will Nathan be doing differently? What would you see?

Mom: He'd smile more, be more easygoing, not so easily frustrated.

School social worker: What else?

Mom: He wouldn't be so down on himself. He would be more accepting of situations, going with the flow, not saying, "It's stupid." He would have more of a sense of humor, be joking, kidding, and teasing.

School social worker: That's a lot. You've both indicated a number of things you would like to be different. Let me ask you two more questions before we stop. On a scale of 1 to 10, with 1 being the worst things have ever been and 10 being the day after the miracle, where would you both say things are at right now?

Nathan: 3 or 4.

Mom: 4.

School social worker: OK. Let's say you came back and things were a little bit better. Nathan, let's say you'd be at a 4 or 5; and Mom, you'd be at a 5. What would be the first sign that each of you would see that would tell you things were a little bit better?

Nathan: I wouldn't be so hyper, more of a balance, not bouncing off walls, not so down.

Mom: Nathan would accept it if things don't go well at school and quit keeping track of things going on. He would talk about positive things at school.

School social worker: [to mother] What kind of positive things would Nathan tell you about school?

Mom: Ah...you know, things like what happened on the track team. How he liked a certain thing

that happened in his classes. Something positive about one of his friends....

School social worker: Hmm? Just good things that happen?

Mom: Yeah.

School social worker: OK, Nathan. Let's just suppose that you were not so hyper and bouncing off the walls. What would you be like then?

Nathan: Just calm, not so negative like Mom says. Doing my work. Getting along with Ms. Jones [the teacher].

School social worker: OK. Between now and the next time we get together, I want you to notice when things are a little bit better and when parts of the miracle occur.

Two weeks later a second family session was held with Nathan and his mother. The school social worker started this session by exploring any small signs of progress since the first session.

School social worker: What's better?

Mom: Nathan had minimal behavioral problems in Ms. Jones's class last week.

School social worker: [to Nathan] You did? How did you do that?

Nathan: I don't know. I just tried harder.

Mom: He was also better at controlling his temper with other kids. He was more normal emotionally, less hyper.

School social worker: Nathan, that's great. What else was better?

Nathan: My morphing voice was less.

The school social worker explored with Nathan how these behaviors were representative of progress toward

solutions. Nathan and his mother indicated that at one point he did become more depressed because of a wrist injury. When asked the scaling question, Nathan ranged from a 3 to a 6, and his mother ranged from a 4 to a 6. When asked for future signs of progress, Nathan indicated that he wanted to control his temper and set a goal to be more helpful. His mom noted that she felt nervous about which Nathan she would see—the irrational Nathan or the fun-loving Nathan. The school social worker then encouraged Nathan and his mother to notice when and how his anger was more controlled. In accordance with the Admission Review and Dismissal committee's recommendation, a full psychological evaluation of Nathan was completed three weeks later. The testing revealed that Nathan had a very superior intelligence level with commensurate achievement. Testing, observations, and teacher and parent ratings suggested an attention-deficit hyperactivity disorder with some concomitant depression and low self-esteem. His mother noted at the time of the testing that there had been no major outbreaks and that Nathan seemed more relaxed and agreeable, told more jokes, and goofed around more. This was really different for him.

Because of the school social worker's and the family's schedules and because Nathan was in a time of testing in his school district, another family session was held eight weeks later. At that session, Nathan came with his father, who had not come to any of his previous sessions.

School social worker: What's better?

Dad: Nathan has a little more control and doesn't let things bother him as much. He can focus longer on things such as geometry and play.

The school social worker then proceeded to explore how these events occurred and asked what other strategies could be helpful. In the process of coconstructing solutions, the school social worker, father, and Nathan concluded that Nathan should repeat instructions, make a checklist of tasks to be done, and cross the tasks off when they were completed. At the end of the session the therapist asked the scaling question.

Nathan: 6 to 8.

Dad: 6 to 8.

School social worker: What would be small signs of progress in the future?

Nathan: I would have less of a hyper streak. I would be more level, not everywhere at once.

School social worker: [to father] How about you?

Dad: Nathan would complete tasks without reminders. He would follow through on tasks.

School social worker: OK. That's good. I would encourage you to notice when those small signs occur.

Conclusion

This case illustrates the solution-focused therapy model with an adolescent with ADHD and his family and reveals the progress Nathan made over time in terms of behavioral self-control. Part of the treatment regimen included a full psychological evaluation and family support to help Nathan achieve his changes. ■

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