A Solution-Focused Approach
to Crisis Intervention
with Adolescents

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SUMMARY. The article provides a description of a solution-focused approach to crisis intervention with adolescents. A description of common developmental and environmental factors that may result in crises for adolescents is presented, followed by an overview of solution-focused therapy. Similarities between solution-focused therapy and strength's-based crisis intervention and intervention with adolescents are discussed. The assumptions and techniques of solution focused therapy that meet the particular needs of adolescents in crisis are presented along with a typical solution-focused session adapted for use with adolescents in crisis. An overview of efficacy research on solution-focused therapy with adolescents is also presented. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2004 by The Haworth Press, Inc. All rights reserved.]*

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ADOLESCENTS IN CRISIS

Adolescents may be at greater risk than adults for experiencing a crisis because the developmental tasks associated with adolescence and daily environmental stressors can require sophisticated coping strategies. An adolescent does not have control over many aspects of daily life and may be more susceptible than an adult to experiencing a situation as a crisis (O'Halloran and Copeland, 2000). Teens may have strained relationships with family members because they are struggling with a desire for more autonomy while continuing to want guidance from adults. Sexual development can result in dissatisfaction with appearance, low self-esteem, and a concern that developmental changes are not normal (Aguilera, 1990). A typical adolescent may experience conflicts with parents and peers, fluctuation in mood, and experimentation with risky behaviors (Arnett, 1999, as cited in O'Halloran and Copeland, 2000). Because adolescents are already engaged in rapid change and, at times, disequilibrium, they are more vulnerable in crisis situations in which they are thrown into a state of further disequilibrium (O'Halloran and Copeland, 2000).

In addition to being more vulnerable to crises because of their stage in development, adolescents are also likely to be exposed to many stressors in their environment that can precipitate a crisis. Such stressors include exposure to violence in schools and gang activity, experiencing the loss of a parent due to divorce, and consequences of alcohol and drug use and unprotected sexual intercourse (Jobes, Berman, and Martin, 2000; O'Halloran and Copeland, 2000; Putnam, 1995).

In a 1997 survey conducted by the National Institute on Alcohol Abuse and Alcoholism, 16% of eighth graders, 25% of 10th graders and 30% of 12th graders reported binge drinking (defined as five or more drinks in a row) at least once in the two weeks prior to completing the survey. These teens are vulnerable to experiencing a crisis because alcohol use is associated with considering and attempting suicide, deaths due to drinking and driving, and risky sexual behavior (National Institute on Alcohol Abuse and Alcoholism, 1997). Drug use among teens may result in similar consequences. Despite decreases in drug use among teens in the past few years, 24.5% of 8th graders, 44.6% of 10th graders, and 53% of 12th graders reported using some kind of illicit

drug in a 2002 survey (National Institutes on Drug Abuse, 2003). Unprotected intercourse also continues to put adolescents at risk for crisis. In 1999, three million teens were diagnosed with a sexually transmitted disease, and 10% of girls between the ages of 15 and 19 became pregnant. Twenty percent of abortions involved teens 19 years old or younger (Alan Guttmacher Instititute, 1999).

Situations at home and at school can precipitate crises for adolescents. High divorce rates mean that more than half of parents' marriages will end in divorce, which can be a source of great stress for adolescents (O'Halloran and Copeland, 2000). They may also experience many stressors while at school. According to survey data collected by the National Center for Educational Statistics in 1999, 8% of students in grades six through twelve reported criminal victimization at school, 8% of students in grades nine through twelve reported being threatened or injured with a weapon on school property, and 5% of students age twelve through eighteen reported that they had been afraid of being attacked or harmed on school property during the past six months (Kaufman, Chen, Choi, Peter, Ruddy, Miller, Fleury, Chandler, Planty, and Rand, 2001).

Determining when a teen is experiencing a crisis is important because of the potential for suicidal ideation. Suicide is the third leading cause of death among teenagers and results in the death of 8 of every 100,000 teens between the ages of 15 and 19. Nineteen percent of teens in grades one through twelve reported that they had considered suicide, and 8.8% reported that they had attempted suicide in 2001 (National Center for Health Statistics, 2002).

DEFINING CRISIS

Defining crisis is difficult because it is the individual's perception of an event that determines whether it is a crisis (Roberts, 2000). The same situation may be called stress for one person, a trauma for another, and a crisis for a third. Many factors, such as stage of development, personality, life experience, and coping strategies, may determine whether an event causes a crisis for an individual (Dulmus and Hilarski, 2003). In order to reduce ambiguity about the meaning of crisis, Roberts (2000) has created a definition of crisis and a model for crisis intervention that represents a synthesis of ideas expressed by Gerald Caplan, Naomi Golan, Howard Parad, and Albert Roberts, and Sophia Dziegielewski. He defines a crisis as a state of psychological disequilibium caused by

an event perceived as hazardous and an inability to use existing coping skills to resolve the crisis (Roberts, 2000). Three criteria must exist in order for an individual to experience a crisis: the individual must have been exposed to a stressful or hazardous event; the individual's perception of that event leads to considerable upset or disruption; the individual is unable to resolve the disruption with previously used coping mechanisms (Parad, 1971, as cited in Roberts, 2000).

Determining when an adolescent is in crisis can be especially challenging. Whether stressors precipitate a crisis for adolescents depends on many factors, such as the teen's resiliency, maturity, and protective factors. Adolescents of the same age may vary widely in their maturity level and their ability to cope with daily stressors. Because adolescents may be more vulnerable to experiencing a crisis than an adult, practitioners working with adolescents cannot assume that their perception accurately reflects an adolescent's perspective (O'Halloran and Copeland, 2000).

A STRENGTHS-BASED APPROACH TO CRISIS INTERVENTION

There are numerous approaches to crisis intervention that differ in style, length of treatment, and the parameters of treatment (Roberts, 2000). Despite the variation among approaches, there are commonalities between the different models. Many approaches emphasize the need for intervening quickly with brief treatment, obtaining a detailed description of the crisis situation and the client's emotional state, and defining clear, specific goals (Roberts, 2000; Berg, 2002; Aguilera, 1990; Golan, 1978). Many traditional approaches to crisis intervention define an intervention as successful if it returns a client to their pre-crisis state of functioning. A strengths-based approach to crisis intervention goes beyond this definition by viewing crisis intervention as an opportunity to develop new coping skills and leave the client with more strengths and resources after the crisis is resolved (Greene, Lee, Trask, and Rheinsheld, 2000). A strengths-based approach to crisis intervention emphasizes active listening, building on inner strengths, and developing new coping skills. During crisis intervention, it is important to maintain a strengths-focused approach that emphasizes joining and active listening in order to adequately understand the crisis from the client's perspective, since the client's perspective defines whether a situation is a crisis (Roberts, 2000; Greene et al., 2000). Examining inner strengths is important because it helps the therapist understand the

strengths on which the therapist can encourage the client to draw in managing the crisis. It is important to develop new coping skills in order to ensure that clients emerge from the crisis with more strengths than they had before. These characteristics are also central to solution-focused therapy and contribute to its potential as an effective model for crisis intervention (Roberts, 2000; Greene et. al., 2000).

The solution-focused approach goes beyond returning a client to their pre-crisis state of functioning. Solution-focused therapy views a crisis as an opportunity for clients to develop new coping skills, which can result in increased resiliency in dealing with future crisis situations. It is appropriate for crisis intervention because it is a brief therapy model that can produce quick change in clients, and it focuses on the client's present situation instead of the history of the problem. Solution-focused therapy aims to use empathy and active listening to understand the client's view of the problem, which is critical in understanding whether a client is experiencing a crisis (Greene et al., 2000). A crisis for one individual may not be a crisis for another (Dulmus and Hilarski, 2003; Roberts, 2000). The solution-focused therapist also works with clients to define concrete, specific goals as quickly as possible and moves quickly toward discussing solutions. This is critical in effective crisis intervention, when clients often feel too overwhelmed to define goals but need to do so quickly to ensure their safety and well-being (Green et al., 2000).

A strength's-based approach has also been described as useful for work with adolescents in crisis. (O'Halloran and Copeland, 2000; Yeager and Gregoire, 2000). Solution-focused therapy is well-suited for work with adolescents in crisis because their stage in development may cause them to feel resentful of a more directive or problem-focused approach to therapy. Adolescents in crisis are likely to view themselves as responsible for negative outcomes in their lives and the therapist may need to help them reduce feelings of self-blame (O'Halloran and Copeland, 2000). Solution-focused therapy minimizes these feelings by emphasizing strengths and helping the adolescent see that their problems exist outside of themselves (Corcoran, 1998). Working with adolescents can also present many challenges in therapy because they may be distrustful of adults. While they still need to feel protected by their families, they want to separate from their parents and gain more independence. Because of these developmental tasks, adolescents are likely to be resistant to engaging in treatment (O'Halloran and Copeland, 2000). Solution-focused therapy communicates a great deal of respect for the client from the beginning and view the client as the expert on the problem. This can reduce feelings of resistance while helping the adolescent

feel that they may already have some of the resources needed to address their problems (Corcoran, 1998).

AN OVERVIEW OF SOLUTION-FOCUSED THERAPY

Solution-focused therapists work to demonstrate great respect for the client and belief that the client is the expert in resolving their problem. They assume that clients have the knowledge, strength, skills, and insights to solve their own problems (Berg, 1994). Four underlying assumptions guide solution-focused therapy sessions:

1. Every client is unique;
2. Clients have the inherent strength and resources to help themselves;
3. Change is constant and inevitable, and small change can lead to bigger changes;
4. Since it is not possible to change the past, the session should concentrate on the present and future (Lipchik, 2002). A review of the main techniques of solution-focused therapy and description of sessions provides an understanding of how the approach draws on client strengths to achieve goals quickly.

Franklin and Biever (1997, as cited in Franklin and Moore, 1999) outline the following steps of a typical first session in solution-focused therapy:

- A conversation between the therapist and client to find out about the client's life
- Gathering a brief description of the problem and the context of the problem
- Asking relationship questions
- Tracking exceptions to the problem
- Scaling the problem
- Using coping questions
- Asking the miracle question to develop solutions
- Negotiating the goal for change
- Taking a session break
- Delivering compliments and tasks or homework assignments

Throughout the intervention, the therapist defines the problem and potential helpful solutions in terms of the client's perceptions. There is continuous reinforcing of clients' strengths and complimenting them for every success in their attempts to cope.

SOLUTION-FOCUSED THERAPY WITH ADOLESCENTS IN CRISIS

Some modifications to the typical solution-focused therapy session may be necessary to make it appropriate for crisis intervention with adolescents. The following represents a description of the steps outlined by Franklin and Biever (1997, as cited in Franklin and Moore, 1999) and suggests some modifications for use with adolescents in crisis:

A Conversation Between the Therapist and Client to Find Out About the Client's Life

This conversation begins the process of joining with the client by understanding the things that are important to the client, the problem-solving strategies the client has used, the client's successes and failures around the presenting problem, motivation level, and the client's resources (Berg, 1994). The therapist takes the position of "not knowing" by laying aside all preconceptions about the problem and its potential solutions (Berg, 2002). Since adolescents of the same age group may vary on each of these factors, the solution-focused approach of laying aside all preconceived notions about the client and the problem can be valuable.

This conversation is helpful for work with adolescents in crisis, because it is important to join with them immediately to begin assessing the potential lethality of their situation, their existing coping skills and resiliency (Greene et al., 2000). The solution-focused approach may be better suited for adolescents than other approaches because of the distrust they often feel for adults (O'Halloran and Copeland, 2000). A respectful, not-knowing approach may decrease such feelings of distrust. It is especially important to establish a supportive working relationship between the adolescent and therapist quickly when the adolescent may be suicidal because it may help them feel more comfortable discussing

their desire to harm themselves (Jobes, Berman, and Martin, 2000; Sharry, Darmody, and Madden, 2002).

Gather a Description of the Problem and the Context of the Problem

Joining with the client continues during this step in the intervention. The therapist allows the client to define the problem and does not impose his or her own ideas about the problem and its potential solutions. The therapist typically works to change the focus of the discussion from the problem to potential solutions. Through the technique of externalizing the problem, the therapist encourages clients to view their problems as separate from themselves and develop confidence that they can overcome the problem (Franklin and Moore, 1999).

Affirming the client's definition of the problem demonstrates the therapist's commitment to understanding the client's perspective (Berg, 2002). This can continue to decrease any resistance an adolescent might feel towards the therapist. While a solution-focused therapist typically works quickly to shift the client's pattern of talking about the problem to talking about solutions, the solution-focused approach to crisis intervention devotes more time to gathering a detailed description of the problem. Because clients are so overwhelmed, they are likely to devote much of the first session to discussing the problem. In a crisis situation, giving the client space to talk about their feelings surrounding the problem and can help the client feel less overwhelmed and help the therapist gain a more complete understanding of the client's perception of the problem and how it has become a crisis for the client (Berg, 2002; Greene et al., 2000). However, the detailed problem description should not take the place of solution-building, because solution-focused therapy assumes that talking about strengths and coping successes can provide a more thorough client assessment than simply asking for a description of the problem (Berg, 2002).

Adolescents who are vulnerable to crises are likely to view themselves as responsible for negative outcomes in their lives (O'Halloran and Copeland, 2000). The solution-focused therapist's reliance on the client's understanding of the crisis can help reveal when an adolescent blames him or herself for the crisis event (O'Halloran and Copeland, 2000). The technique of externalizing the problem may help reduce feelings of self-blame because the problem is viewed as existing separately from the individual (Corcoran, 1998).

If an adolescent expresses suicidal ideation, the therapist will need to ask questions that specifically address the lethality of their intentions. This may require a more direct questioning approach than that usually taken in solution-focused therapy. If the adolescent is actively suicidal and has a plan for suicide, the therapist may need to hospitalize the client instead of proceeding with solution-focused therapy. However, the techniques used in therapy to join with the clients and obtain a definition of the problem from the client's perspective can ensure that the therapist is assessing the lethality of the situation as accurately as possible (Berg, 2002).

Asking Relationship Questions

Relationship questions ask the client how others, such as parents or teachers, would perceive the presenting problem. They help determine what the client believes are others' perceptions of the problem. These questions are helpful in understanding who is involved in the problem and who are potential resources for the client. Relationship questions are helpful in working with adolescents in crisis because they give the therapist information about who is involved in the teen's definition of the crisis situation. The teen's answers to these questions also help the practitioner know who to consult during the treatment and whom to include in sessions (Franklin and Biever, 1997). These questions can also assess for resiliency since spending more time with peers and social skills are associated with resiliency (O'Halloran and Copeland, 2000).

Tracking Exceptions to the Problem

In order to shift client's focus away from the problem to times when the problem was not present, the therapist asks about times when the presenting problem could have happened but did not. In finding examples of times when the problem was absent and how they accomplished this absence, clients may feel that they already have the skills and knowledge to succeed (de Shazer, 1988; Berg, 1994). When a client is having difficulty in thinking of exceptions to the problem, the therapist can ask for times when the problem was less severe or less frequent (Berg, 1994).

As with any other client, practitioners can ask adolescents in crisis about exceptions to the problem to engender a sense of hope that things will get better. This can be helpful in crisis situations, since clients who are overwhelmed and are currently unable to use coping skills to resolve

the crisis (Roberts, 2000). With adolescents, this can be especially problematic because they have difficulty seeing beyond the present situation and believing that things will improve (Jobes et al., 2000). Finding exceptions to the problem encourages clients to see that they have been able to cope with similar problems in the past, that the problem could possibly be worse, and that they can imagine a future without the problem. This technique can help adolescents think of ways they may be able to cope with the current crisis (O'Halloran and Copeland, 2000).

Scaling the Problem

Scaling questions are used for assessment in many areas, such as self-esteem, prioritizing problems, perceptions of hopelessness, and progress towards achieving goals. Typically, scaling questions ask clients to rate where they are on a scale from 0 to 10 with 0 being the worst/lowest and 10 being the best/highest. Scaling is a versatile technique that most clients easily understand and can be especially helpful when clients are having a difficult time seeing their progress (Sklare, 1997; Berg, 1994).

Scaling questions are useful in gathering many different kind of information throughout solution-focused therapy sessions (Berg, 1994). They can be very helpful with children and adolescents because even young children can relate to the idea of rating something on a scale from one to ten (Berg, 1994). They are also helpful in identifying potential solutions to a problem. If a client ranks the situation as less problematic in successive sessions, the therapist asks the client about the reasons for the improvement (Greene et al., 2000; Berg, 2002). This technique also places the responsibility for evaluating progress toward achieving goals on the adolescent (Corcoran, 1998).

Scaling questions are helpful in assessing an adolescent's safety, feelings of depression or suicidality, and perceived coping ability. Asking how seriously an adolescent is considering suicide on a scale from 1 to 10 can help the solution-focused therapist assess the lethality of the crisis situation and how well the adolescent perceives their own coping ability (O'Halloran and Copeland, 2000; Sharry, Darmody, and Madden, 2002).

Using Coping and Motivation Questions

In asking coping questions, the practitioner begins with the client's definition of the problem and asks how they have been able to cope with this problem until now. The practitioner listens for any strengths in the client's explanation and directs coping questions based on the strengths and resources the client has used (Berg, 1994). Coping questions can be

helpful when an adolescent in crisis has difficulty identifying exceptions to the problem or past successes in dealing with a similar problem (Greene et al., 2000). The therapist asks how the client has managed to function as well as they have given the presence of the crisis situation. Asking a coping question such as, "What have you found helpful so far?" demonstrates that the therapist thinks the client has already learned some coping skills. This further emphasizes the client's strengths and can instill hope and motivation in clients (Berg, 2002).

Coping questions can be helpful with suicidal adolescents in determining the appropriate treatment. Therapists working with clients in crisis are often quick to consider medication and hospitalization. If they ask coping questions first, they can make a better determination of how well the client is coping and whether more extreme measures are needed to ensure the client's safety (Berg, 2002).

Asking the Miracle Question to Develop Solutions

The miracle question is used to help the client formulate a well-defined and achievable goal. The therapist asks the client to imagine what their lives would be like if the problem were suddenly solved. In shifting client's focus away from the presenting problem so they can envision their lives after their problems are resolved, the miracle question engenders hope and defines the desired outcome in the client's terms. In addition, the therapist also uses the miracle question to help clients identify ways that the solution may already be occurring in their lives (Berg, 1994).

The miracle question may not be appropriate in working with adolescents in crisis. In order for the miracle question to be helpful, the client must be able to consider the possibility that the problem can be solved (Berg, 2002). Clients in crisis and especially adolescents who have difficulty seeing beyond the present situation may be too overwhelmed to begin considering what life would be like if the problem were suddenly and magically solved (Berg, 2002). If the client is able to consider what life would be like after the crisis is resolved, the miracle question can be helpful in defining concrete, specific goals (Greene et al., 2000). It may be helpful to ask a miracle question about a small aspect of the crisis situation instead of asking what it would be like if the crisis were solved altogether (Berg, 2002).

Negotiating the Goal for Change

The therapist and client work together to develop goals. Goals need to be specific, attainable, and important to the clients so that they will be

motivated to accomplish them. Occasionally, clients will state harmful or unlawful goals, which the therapist cannot support. In this case, the therapist asks questions about the desired outcome of the goal instead of the harmful goal itself and helps the client formulate a positive goal that can achieve the desired result. If, for example, the client is a teenager who wants to run away from home, the therapist could ask questions to help identify why the client wants to run away from home and then co-construct healthier goals that the client can attain (Sklare, 1997).

Solution-focused therapy emphasizes the importance of setting small, specific, achievable goals. This is especially helpful for adolescents in crisis because they feel that the problem is beyond their control and may need to work toward small goals (Roberts, 2000). Adolescents often define their problem in vague, ambiguous terms and may need help creating manageable goals (Corcoran, 1998). Solution-focused goals are based on the client's ideas about potential solutions and are expressed in their own words. Such goals are important in crisis situations, because a client is more likely to work toward a goal in which they feel personally invested (Greene et al., 2000). Goals are articulated in positive terms indicating what clients want to be present in their lives instead of what they want to be absent. This is important in engendering hope and creating goals that define concretely actions the client can take to improve their situation (Berg, 1994) and can be especially important when working with a suicidal adolescent (Sharry et al., 2002).

With a suicidal adolescent, the session goals will need to include removing any means for self-harm, such as pills or weapons, making a contract with the adolescent that they will not harm him or herself, scheduling the next session and phone contacts between sessions, if necessary, referring the adolescent for an assessment to determine whether medication is needed, decreasing isolation by mobilizing friends and family to be available to the adolescent, considering hospitalization if the adolescent cannot negotiate his or her safety (Jobes et al., 2000). While these techniques are not part of a traditional solution-focused therapy session, the approach is flexible in incorporating other techniques as long as they are used because the client sees them as helpful.

At this stage in the session, after exploring coping questions and scaling questions, the client may be too overwhelmed to identify any means of coping with the crisis. If this is the case, the therapist may need to consider alternatives such as medication or hospitalization. The solution-focused approach remains helpful because clients may be willing

to consider such alternatives after forming a close, supporting relationship with the therapist (Berg, 2002).

Taking a Session Break

Solution-focused therapy sessions typically include a break near the end of the session. The break is important in allowing the therapist time to formulate feedback and genuine compliments for the client as well as generating ideas for appropriate homework tasks.

Delivering Compliments and Tasks or Homework Assignments

The therapist delivers genuine compliments based on the client's strengths, such as those elicited through exception questions or the miracle question. Delivering compliments is another step in the process of helping clients see their own strengths and increase their awareness that they have the ability to solve their problems. With an adolescent in crisis, genuine compliments can continue the process of identifying client strengths and resources that they already have and can use to resolve the crisis. The therapist should be only use genuine compliments based on session content and should not overcompliment adolescents because they are likely to view this behavior as insincere.

The therapist and client also set a behavioral task for the client to complete before the next session. Tasks are often defined by behaviors the client has indicated as helpful through exception questions or coping questions. The therapist will give the client the talk of "Doing more of the same" for behaviors that clients have describes as helpful in coping. Clients will be directed to "do something different" when they indicate that they have tried one way of coping numerous times with no success (Berg, 1994; Berg, 2002). Such strategies result in concrete tasks that the adolescent may be likely to complete, because they are based on strategies that the client has defined as helpful or not helpful.

IMPORTANCE OF CRISIS INTERVENTION IN A SCHOOL SETTING

Any approach to crisis intervention with adolescents must be useful in a school setting. Many precipitating events of a crisis for adolescents may take place while they are at school. Because depressed or suicidal adolescents may express suicidal ideation at school, schools should be

prepared for how to thoroughly assess students and respond quickly with appropriate treatments. Addressing crisis situations in a school setting requires great collaboration to ensure that the students' needs are met. Teachers, counselors, social workers, and other staff may have different understandings about the best approach for the student, which can lead to a situation in which no one addresses the crisis situation appropriately (Kline, Schonfeld, and Lichenstein, 1995; Poland, 1994).

Solution-focused therapy can be applied well to situations that arise in a school setting because of its emphasis on active listening and focusing on strengths, which can facilitate collaboration with others involved with the client. Solution-focused therapy allows for the use of tools from other models as long as they are used thoughtfully to accommodate the client's goals instead of attempting to fit the client's situation into a predetermined mold defined by that approach. Therefore, solution-focused therapists in a school setting collaborate with students, parents and teachers in developing interventions. The therapist adopts the stance that there are many approaches that may result in solutions and respects the unique ideas, beliefs, and styles of students, parents, and teachers (Murphy, 2000). A collaborative approach to crisis intervention in which all staff members involved with a student work together can develop an atmosphere promoting sharing and more personal and positive relationships between students and staff that can last after the crisis is resolved (Kline et al., 1995). The solution-focused practice of defining small, concrete goals is also more realistic is a school situation in which those involved have limited time and resources (Murphy, 1996).

EFFICACY OF SOLUTION-FOCUSED THERAPY WITH ADOLESCENTS

While much more research is needed on the efficacy of solution-focused therapy, there are a few existing studies that demonstrate its effectiveness with adolescents. Many of these studies were conducted in a school setting as well. Findings suggest that solution-focused therapy results in positive outcomes for students on self-esteem measures and coping measures (Lafountain and Garner, 1996), a reduction in acting-out behaviors and other behavior problems (Franklin, Biever, Moore, Clemons, and Scamardo, 2001; Franklin, Corcoran, Nowicki, and Streeter, 1997; Corcoran and Stephenson, 2000; Newsome, 2002), reaching goals (Newsome, 2002; LaFountain and Garner, 1996; Littrell,

Malia, and Vanderwood, 1995), and improved social skills (Newsome, 2002).

Not all findings conclusively support the efficacy of solution-focused intervention. Littrell et al. (1995) found that each of three brief-therapy approaches were equally in adolescents reaching their goals in many areas, even though participants in solution-focused therapy achieved their goals more quickly than did adolescents in the other two conditions. Springer, Lynch, and Rubin (2000) found no significant treatment effects on children's self-esteem in their study evaluating the effectiveness of a solution-focused approach with Hispanic children of incarcerated parents.

While some of the studies have well-controlled designs or moderately controlled designs, many of the studies have design limitations. Some of the studies lack a comparison group (Newsome, 2002; Corcoran and Stephenson, 2000) or had a comparison group but did not use random assignment (Springer et al., 2000). Others used single case designs which may have limited external validity (Franklin et al., 2001; Franklin et al., 1997), or used subjective measures in evaluating progress (LaFountain and Garner, 1996; Corcoran and Stephenson, 2000), and limited monitoring of treatment fidelity (Corcoran and Stephenson, 2000). Despite such limitations, the findings of most of the outcome studies evaluating solution-focused therapy with adolescents demonstrate that solution-focused therapy is a promising model and warrants further research on its effectiveness. Research is needed to specifically investigate whether solution-focused therapy is effective when applied to adolescents in crisis.

SUMMARY AND CONCLUSION

Many basic solution-focused techniques are consistent with practices recommended by those advocating a strengths-based approach to crisis intervention. Roberts (2000) emphasizes establishing rapport and communication and identifying major problems quickly in crisis intervention, which is consistent with the solution-focused approach of immediately joining with the client and understanding the client's definition of the problem. Dealing with feelings and providing support, which is consistent throughout the solution-focused therapy session, is also important in crisis intervention (Roberts, 2000; Berg, 2002; Greene et al., 2000). Exception questions, coping questions, and the miracle question allow the therapist to explore coping skills and strengths cli-

ents already have which can be helpful in resolving the crisis. The solution-focused practice of defining specific, achievable goals quickly is consistent with the need in crisis intervention to define concrete goals that will ensure the client's safety and a resolution to the crisis that will result in increased strengths and coping skills (Greene et al., 2000).

While a crisis represents a painful disruption in individuals' lives, it also has the potential to promote growth and new coping skills (Dulmus and Hilarski, 2003; Roberts, 2000; Berg, 2002). Crisis intervention presents an opportunity for those working with adolescents to strengthen their skills and their self-esteem at a time when they may be the most vulnerable (O'Halloran and Copeland, 2000). The solution-focused approach is well-suited for work with adolescents because of its emphasis on moving clients beyond a resolution of the crisis situation to developing an increased awareness of their strengths and a belief that they have the resources to cope with their problems. Learning solution-focused strategies during adolescence can promote a sense of strength and efficacy. It is the strategy of the solution-focused therapist to "leave no footprint." In other words, the client should feel that they alone are responsible for their successes (Berg, 1994). Leaving adolescents with this sense of self-confidence can help them cope more effectively with the many stressors they may face in the future.

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