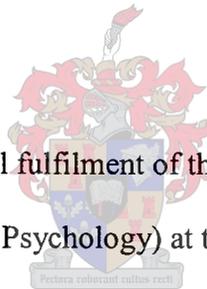


**THE IMPACT OF SOLUTION-FOCUSED BRIEF THERAPY ON YOUNG
YOUTH OFFENDERS**

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Assignment presented in partial fulfilment of the requirements for the degree of
Master of Arts (Counselling Psychology) at the University of Stellenbosch



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STATEMENT

I, the undersigned hereby declare that the work contained in this assignment consists of my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature

Date

SUMMARY

The aim of this project was to evaluate the effectiveness of Solution-Focused Brief Therapy (SFBT) in a South African Youth Centre for young offenders, to which the court had sentenced them for two years. The study focused on the competencies and strengths of youth offenders, as well as on their capacity to find solutions to their problems, whilst being realistic and trying to accomplish positive change within the limits of the youth centre facility. An experimental and control group design was used in order to assess the impact of the therapeutic intervention.

The effectiveness of the intervention was evaluated within three main domains of human experience: (1) subjective discomfort, (2) interpersonal relationships, and (3) social role performance. Two measures were used, namely the OQ-45.2 (outcome questionnaire) and unstandardised scaling questions relating to participants' personalised goals. Results show that no statistically significant improvement had occurred on the three measured dimensions. However, data obtained from the scaling questions reflected a more complete picture of the three areas of functioning identified and explored in this study.

Improvement towards the achievement of young offenders' personalised goals seemed to be rapid at first, followed by a slightly slower rate of improvement and subsequent stabilisation. Scaling questions proved to be a useful technique for making complex aspects of these young offenders' lives more concrete and accessible to both the therapist and themselves. SFBT proved to be an effective method of intervention within group format in a facility for young offenders.

OPSOMMING

Die doel van die navorsingsprojek was om die effektiwiteit van Oplossingsgerigte Terapie binne 'n Suid-Afrikaanse jeugsentrum vir jong oortreders, waartoe hulle vir twee jaar deur die hof gevonnissen is, te evalueer. Hierdie studie se fokus was op die bevoegdhede en sterk punte van jeugdige oortreders, sowel as op hul vermoë om oplossings vir hul probleme te vind. Hierdie oogmerk was terselfertyd realisties in die poging om positiewe verandering binne die beperkinge van 'n jeugsentrum teweeg te bring. 'n Eksperimentele en kontrolegroepontwerp is gebruik om die impak van die terapeutiese intervensie te evalueer. Die effektiwiteit van die ingreep is ten opsigte van drie hoof areas wat verwant is aan menslike ervarings geëvalueer: (1) subjektiewe ongemak, (2) interpersoonlike verhoudings, en (3) sosiale rolvervulling.

Twee meetinstrumente is gebruik, naamlik die UV-45.2 (uitkomstevraelys) en ongestandaardiseerde skaleringsvrae wat verwant was aan deelnemers se persoonlike doelstellings. Resultate het getoon dat geen beduidende statistiese verbetering in die drie dimensies plaasgevind het nie. Data wat egter deur die stel van skaleringsvrae ingewin is, het 'n meer volledige beeld van die drie areas van funksionering wat in die studie geïdentifiseer en verken is, gereflekteer.

Dit blyk dat die verbetering in die jong oortreders se persoonlike doelstellings aanvanklik vinnig geskied het, en gevolg is deur 'n effense stadiger tempo van verbetering en stabilisering. Volgens die navorsingstudie blyk dit dat skaleringsvrae 'n baie suksesvolle tegniek kan wees om komplekse aspekte van hierdie jong oortreders se lewens vir beide die terapeut en hulself meer konkreet en meer bereikbaar te maak. Dit blyk ook dat Oplossingsgerigte Terapie 'n effektiewe intervensiemetode binne groepformaat in 'n inrigting vir jong oortreders is.

It is a rule within the Department of Psychology that the report of research may take the form of an article which is ready for submission for publication to a scientific journal.

This research project is the equivalent to the prescribed thesis and is thus in accordance with the given requirements.

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My father, sister and Pieter for their constant support, love and encouragement.

I dedicate this thesis to the memory of my mother.

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1. INTRODUCTION

South Africa's rising crime rate amongst the youth between the ages of 14 and 25 is very troubling (Cassidy, 2002). However, this is not just a South African problem, as youth delinquency is on the increase in many other countries as well. Juvenile detention and correctional populations have grown significantly, as well as the number of juveniles waived or transferred to the adult criminal justice system. Unfortunately, it seems as if the already stressed juvenile justice system lacks adequate fiscal and programmatic resources to identify and effectively intervene with serious, violent, and chronic offenders (Wilson & Howel, 1993). Lindfors and Magnusson (1997) found that young offenders against the law often give up hope of ever living ordered lives. Many of them have a limited belief that they will be able to break away from the life they are used to: a life of drug abuse, crime and imprisonment.

In today's modern times, there has been a natural tendency for clients who undergo therapy to expect noticeable improvement within a short period of time (Godsall, Emerson & Dupe, 2000). According to Aubuchon and Crosby (in Tohn & Oshlag, 1995), mental health sectors all over the world are also faced with the diminishing availability of staff and trends toward managed care. Therapists therefore need to consider looking for briefer models of therapy, because of the increasing demand for services and limitations on budgets (Tohn & Oshlag, 1995). This is also true for South African therapists. With its focus on the respect for cultural differences and variety of worldviews, the Solution-Focused Brief Therapy (SFBT) model would be well suited for the rich cultural diversity of the South African population.

One of the biggest advantages of SFBT is that it is a very empowering model for treatment and can bring about rapid shifts in thinking and behaviour. Other advantages are its cost-effectiveness, its equal effectiveness for all social classes, and worker burnout prevention resulting from increased responsibility for change resting with the client. SFBT can be used with

varying success with most types of clients in most settings. Best results, however, are obtained with motivated clients who are willing to change (Harris, n.d.).

In a developing country such as South Africa, with its limited resources and the need to constantly face changes in the managed mental health sector, there is a demand for therapists to adapt to new rules, requirements and therapy techniques. According to Bernstein (in O'Connell, 1998), the SFBT model may be more suited to the restricted language code of many people. This model places emphasis on the use of descriptive language, and avoids the use of abstractions. It should be an effective model in the South African context with its vast range of different languages and many illiterate citizens.

The **primary aim** of this research project was to evaluate the effectiveness of Solution-Focused Brief Therapy in a South African Youth Centre for young offenders. The focus was on youth offenders' competencies, strengths and their capacity to find solutions to their problems, whilst being realistic about the amount of accomplished positive change within the limits of the youth centre facility (Lindforss & Magnusson, 1997). A **secondary aim** was to contribute to the mission of many juvenile detention centres across the world: to empower the youth and to make it possible for young offenders to fulfil and maintain their place as rightful citizens of their communities.

Solution-Focused Brief Therapy (SFBT), as a briefer form of therapy, is not so much about the number of sessions, than about placing more emphasis on the establishment of a clear focus for treatment (Tohn & Oshlag, 1995). This counselling model was developed in the late 1970s at the Brief Family Therapy Centre in Milwaukee, USA, by therapists Steve de Shazer and Insoo Kim-Berg (Harris, n.d.). It is based on the assumption that clients already have the skills to solve their problems, but have often lost sight of these abilities because the problems loom so large that skills and strengths are overshadowed (Harris, n.d.).

Therapists believe that it is easier and more profitable to construct solutions than to dissolve problems, assuming it would be easier for the client to repeat already successful behaviour patterns, than to try to stop or change existing symptomatic or problematic behaviour. Therapists focus on exceptions to the problem, believing that noticing even very small successes could lead to an increase in motivation to succeed (Harris, n.d.)

Two well-known techniques used in SFBT are the **Miracle Question** and the **Scaling Question**. The miracle question is used as a method to introduce a future where change is possible, and to begin to formulate short- and long-term goals toward such a future. O'Connell (1998) states that the miracle question aims to identify existing solutions and resources and to clarify the client's goals in realistic terms. According to De Shazer (in Miller & Duncan, 2000), the miracle question can help clients to identify and clarify goals in therapy, and to generate the means to achieve them. The imagery format gives the client permission to rise above negative and limited thinking and to develop a picture of the solution. According to O'Connell (1998), the way we picture the future often determines how we act in the present.

The scaling question is used as a method to anchor clients' realities and to help them to become aware of the fact that they are making changes to presenting problems (Franklin, Corcoran, Nowicki & Streeter, 1997). This technique was developed by de Shazer, Berg and colleagues. It involves the therapist and the client in co-constructing the client's problems and goals along a 10-point continuum (or another ordinal scale). According to Franklin et al. (1997) the scaling technique seems to be a natural approach to collect outcome data.

There has been an increase in the popularity of brief group work, which represents a number of paradigm shifts that have taken place in society. The primary power of the solution-focused therapy group is the influence that members have on each other (Sharry, 2001). According to Sharry (2001), therapy in effect is a process of empowering and "reconnecting" clients to the resources that exist within their lives and of encouraging them to take charge of their own

healing process. The aim of brief group work is essentially to bring people together to support and encourage one another towards similar goals, values of empowerment and self-healing. In addition, it gives group members access to their own resources, as well as to those of other group members. A group setting has the advantage of providing a richer and more diverse environment for learning and could have a more powerful impact on the individual. It also allows group members the opportunity to discuss one another's ideas and opinions. The group setting could create a sense of empowerment, enabling members to feel more confident in challenging ideas and adapting them in their own situation (Sharry, 2001).

Solution-Focused Brief Therapy differs from traditional therapies in that it does not focus on the problem, but instead focus on the solution, and the preferred futures and goals of the clients (Sharry, 2001). The SFBT model thus is in accordance with the mission and aim of the Eureka Youth Centre (where this research was conducted) of creating a safe environment where youthful offenders are accepted individually, and where they can develop to their full potential. The developmental approach in this Youth Centre is based on the following assumptions, which are closely related to the assumptions of the SFBT model:

- Focusing on strengths rather than pathology
- Building competency rather than attempting to cure
- Encouraging trial-and-error learning
- Working with the total person, not the so-called pathology or problem
- A strong belief (reflected in practice) in the potential within each client

This research project was conducted at the Eureka Youth Centre in Slanghoek, just outside Rawsonville in the Western Cape. It is a place where boys between the ages of 14 and 18 are given a second chance to rebuild their lives after having been sentenced by the court. The majority of these young offenders are from rural areas, with many of them suffering from

learning difficulties. At this youth centre, there are fewer restrictions and the security measures do not allow for prison wardens or the barring of windows and doors.

Eureka Youth Centre follows a developmental health model within the context of the child and youth care system, which is in accordance with the assumptions of the SFBT model and the United Nations Convention on the rights of the child (National Association of Child Care Workers, n.d.). The United Nations Convention on the Rights of the Child is fundamental to child and youth care work. A multi-disciplinary team consisting of an occupational therapist, a social worker, a psychologist and a remedial teacher is assigned to each youth upon admission. After an initial interview with each individual, a unique individual development programme is created to identify potential risks and problems to be addressed, as well as the strengths and potential that can be emphasised and developed. This is a collaborative process, in which a high premium is placed on each young person's input into his own developmental plan. A revision of this plan takes place after a 6-month period (Eureka Youth Centre, n.d.).

Youth delinquency is on the increase all over the world. School studies suggest that Grade 8 learners (14-year-olds) are the most alienated and violent of all delinquents (Cassidy, 2002). According to recent research undertaken in Great Britain the proportion of 14-to 17-year-olds admitting to breaking the law have risen by 14% during the past few years (Cassidy, 2002). Juvenile delinquency laws are designed to provide treatment, rather than punishment, for juvenile offenders. Research done in Great Britain shows that about 4% of all children between the ages of 10 and 18 appear in juvenile court during any year. Many youngsters report taking part in one or more minor offences (Chang, n.d.).

Research done in South Africa by the National Institute of Crime Prevention and Reintegration of Offenders (NICRO) has shown that the majority of young offenders referred are property offenders (85%), 6% had committed violent crimes, 9% were victimless crimes. Of these young offenders, 74% were males, whereas 26% were females (Muntingh & Monaheng,

n.d.). In a literature review Chang (n.d.) found that most studies on delinquency have focused on family relationships, or neighbourhood, or community conditions. According to these studies, children do not become delinquent for any single reason. However, family relationships, especially those between parents and individual children, have been the focus of several studies. An early study comparing delinquent and non-delinquent siblings indicated that more than 90% of the delinquents had unhappy home lives and felt disconnected from the circumstances of their lives. It seems that delinquency appeared to be the obvious solution, whatever the nature of the unhappiness experienced by these young children. A series of studies have shown that delinquency rates are above average in the poorest sections of cities. Such areas have many broken homes, high rates of alcoholism, poor schools, high unemployment rates, few recreational facilities and high crime rates. Many young people see delinquency as their only escape from boredom, poverty and other problems (Chang, n.d.).

In South Africa, young people drawn into crime are often battling with fractured family and community relationships (Muntingh & Monaheng, n.d.). According to a report by the Independent Projects Trust (1999) produced at the request of the National Secretariat for Safety and Security, many South African children are born, reared, mature, marry and die in violent situations, owing to a number of historical factors. Some have become so immune to violent actions that they see violence as an acceptable way of expression and as a way of channelling their emotions. Schools located in disadvantaged areas, where the culture of violence reigns, are plagued with violence, crimes, gangs, drugs and other related problems.

Key risk factors described in the literature, and without any particular ranking, are poverty, race, age, location (i.e. where you live), gender, having been victimised, coming from a dysfunctional family, doing poorly at school and substance abuse. These risk factors do not themselves cause criminality but rather, over time, influence the likelihood of criminal behaviour. According to the above mentioned report, the resilience factors which support a child

exposed to the so-called “risk factors” to NOT become violent or a perpetrator of crime, are factors such as high self-esteem, trust, self-reliance, assertiveness, compassion and the ability to conceptualise and solve problems (Independent Project Trust, 1999).

According to Lindforss and Magnusson (1997), the prison situation provides an opportunity for the inmate to concentrate his efforts on the therapeutic work to a greater extent than the more distracting situation that commonly exists outside the prison. A two-year experimental study was undertaken by the Stockholm Regional Prison and Probation Administration at Hageby Prison to create an improved release situation for prisoners through the use of solution-focused network therapy (Dissel, 1995). A secondary aim of this study was to see whether this form of treatment had an effect on relapse into crime, substance abuse, and general adjustment in the community. Results showed that by 12 months after release 53% of those in the experimental group had committed a new offence leading to one or more sentences to imprisonment or probation. The corresponding figure for the control group was 76%. The difference between the groups (23%) is significant on the 5% level. After comparing the two groups over a one-year observation period, it was apparent that the control group had committed more serious, as well as a greater number of offences than the experimental group (Dissel, 1995).

Three single-case AB designs (designs in which the target behaviour was clearly specified, and repeated measurements were taken throughout the A and B phases of experimentation) using client self-anchored scales to measure outcome, were conducted in Austin, Texas to measure the progress of adolescents and families receiving Solution-Focused Therapy in a youth agency (Franklin et al., 1997). Client self-anchored scales are compatible with the scaling technique frequently used in SFBT, which was also used in the present study as a means to measure progress in the three previously mentioned domains of functioning. In the first case of a 15-year old and his family, results showed that, after the use of SFBT as part of the brief family systems approach, pre-treatment changes were maintained and that progress continued after a three-

month follow-up. In the second case, of a 14-year old white male who refused to live with his father, results also indicated significant changes from baseline to intervention. The results of the third case, of a 14-year old Hispanic female who was brought for therapy by her single-parent mother, indicated that the changes from baseline to intervention were statistically significant. A three-month follow-up indicated that their problems were less severe than before they started therapy (Franklin et al., 1997).

According to Dissel (1995), the correctional services in South Africa have come under increasing criticism and attention from non-governmental groups and parliamentarians. Several countries have demonstrated their support for the transformation of penal institutions. In order to assist in the development of transformation of the penal institutions in South Africa, a two-week Correctional Service tour to Denmark, Holland and London was organised by the Pretoria office of the Institute for Democracy in South Africa (IDSA) in May 1995. Based on a report on this Correctional Services Tour, it is possible to draw a few comparisons between the Eureka Youth Centre and the prisons and correctional institutions in Denmark and the Netherlands.

One of the shared fundamental principles is that the conditions in prison must emulate those outside prison as closely as possible (Dissel, 1995). This is the “normalisation” principle, which also forms part of the Eureka Youth Centre’s foundation. Other important shared elements of the Youth Centre and the Danish prison system are the concepts of openness to the public and prisoner, and the responsibility of the individual for his actions (Dissel, 1995). It is clear that the Eureka Youth Centre shares its holistic approach and focus on the positive qualities of each individual's personality with some of the detention centres and remedial centres for juveniles in the Netherlands, for instance the De Jock Detention Centre. According to Dissel (1995), the aim of the De Jock Detention Centre is to stimulate children to involve themselves in education, either at the centre or outside it by means of workshops. As in the case of Eureka, there is a focus on work training, with metal, wood and art workshops being made available, and examples of

their impressive work displayed in the centre. In addition, emphasis is placed on the re-establishment of family contact and on evaluating where to place a juvenile on completion of his term at the centre. A specific programme is laid out for the juveniles, with the aim to accustom them to daily routines and to develop their social skills (Dissel, 1995). This programme can be compared with the life skills programmes that are offered at the Eureka Youth Centre.

In the age of accountability and with the increasing demands of managed care, the building of an empirical basis for the effectiveness of SFBT could become a critical factor in determining whether this therapy will be included among preferred treatments for reimbursement by managed care companies (Franklin et al., 1997). To date, only a few outcome studies have been done with regard to SFBT for young youth offenders, but there seems to be an increase in the building of an empirical basis.

According to Lindfors and Magnusson (1997), young offenders of the law have told their unhappy stories to different people over the years, without these efforts leading to any positive change in their careers of crime and drug abuse.

The SFBT model is based on the assumption that continued focus on the problem will not lead to change, and instead focus on how the individual moves toward change and how circumstances change for him. Solution-Focused Brief Therapy views change as inevitable and constantly occurring. The aim for the solution-focused therapist is to look for small changes and to amplify it, instead of being negatively preoccupied with a particular problem (O'Connell, 1998; Sharry, 2001). A positive orientation toward solutions could enhance the different levels of functioning in the client's emotional and symptomatic state and his interpersonal relationships, and successfully meet the challenges of important life tasks.

The theoretical assumptions pose the research question: Could the Solution-Focused Therapy approach be an effective therapeutic intervention to reduce youthful offenders' symptomatic distress, increase the quality of their interpersonal relationships, improve their

functioning in social roles and life tasks, and inevitably lead to an improved release situation for some?

The focus of this study is to assess the effectiveness of Solution-Focused Brief Therapy with its brief strategies in the lives of young youth offenders in South Africa, with an emphasis on three content domains of functioning: (1) subjective discomfort, (2) interpersonal relationships, and (3) social role performance. In addition, this study comprised an attempt at assisting young offenders in identifying and realising their personal goals with a view towards their preferred futures.

2. METHODOLOGY

An experimental control group design was used to assess the impact of the therapeutic intervention. Participants were selected from a list of all literate male offenders and randomly assigned to three experimental groups of six participants each, and one control group, consisting of eighteen participants.

2.1 Participants

The experimental groups and control group consisted of an even distribution of young Afrikaans-speaking males between the ages of 14 and 18, who had been sentenced by the court to detention periods of two years. All the participants were people of colour from rural areas, with many suffering from reading as well as learning difficulties. They were sentenced for various types of offences ranging from crimes of an economical, aggressive and/or sexual nature, as well as substance-related crimes.

Some of these participants had not been sentenced yet, and were awaiting trial. According to data gathered by means of a biographical questionnaire, these young offenders experienced a variety of stress factors in their lives, such as loneliness, physical distance from family and

friends, uncertainty regarding the future, anxiety surrounding sexual relationships and finances, as well as occupational uncertainty.

2.2 Measuring Instruments

A biographical questionnaire was developed and administered to the participants. Data concerning age, home language, educational qualifications, support systems (in terms of family and friends), living area, stress factors present in their lives, and crimes for which sentence was passed, were generated in this way.

The OQ-45.2 (Outcome Questionnaire) was used to measure functioning in three main domains of experience. These domains are based on Lambert's conceptualisation of general levels of wellbeing (Mueller, Lambert & Burlingame, 1998). Lambert has suggested that three aspects of a client's life can be monitored. These are (a) subjective discomfort (intrapsychic functioning), (b) interpersonal relationships, and (c) social role performance. These areas of functioning suggest a continuum covering how the person feels inside, how he or she is getting along with significant others and how he or she is doing in important life tasks (Mueller et al., 1998).

The OQ-45.2 includes not only items assessing the intensity of symptomatic complaints (mainly anxiety and depression, poor interpersonal relationships, and dysfunction in social roles), but also items measuring positive mental health, or quality of life, or wellbeing (Lambert, Okiishi, Finch, & Johnson, 1998). The OQ-45.2 is a brief screening and outcome assessment scale that attempts to measure the subjective experiences of a person, as well as the person's way of functioning in the world (Lambert et al., 1997). The questionnaire consists of 45 five-point Likert-scale items ranging from never, rarely, sometimes, frequently, to almost always. Items that were selected addressed commonly occurring problems across a wide range of disorders. These chosen items were also selected in order to tap those symptoms that are most likely to occur across a range of clients, regardless of their unique problems. In addition, the number of

items was limited so that the length of the questionnaire would be tolerable for clients and suitable for repeated testing. A low score on each scale is indicative of improvement in each separate dimension, whereas a high score can be viewed as a lack of improvement, or a lack of adequate interpersonal relationships, a high degree of subjective distress and inadequate social role performance (Lambert et al., 1997).

The OQ-45.2 is self-administering and requires no instructions beyond those printed on the answer sheet, but under special circumstances, such as prevailed in this study with participants experiencing reading and/or learning difficulties and behaviour problems, the questionnaire can be administered by reading items to clients. The questionnaire was designed to address limitations of other current outcome measures. The scale is available at a low cost, sensitive to change over short periods of time, while maintaining high levels of reliability and validity. Internal consistency was found to be high and test-retest values were significant at the 1% level (Lambert et al., 1997). Research has shown the scale to be stable, which is useful for tracking client progress through therapy. Concurrent validity for the OQ-45.2 and its individual domains with the criterion measures were all significant beyond the 1% confidence level. It appears that the OQ-45.2 has high to moderately high concurrent validity with a wide variety of measures that are intended to measure similar variables. According to Lambert et al. (1997), correlations are strongest with the Total Score, whereas the status of the three subscales is less certain.

Scaling questions were used as an alternative to measure progress toward participants' personalised therapy and future goals. De Shazer and his colleagues (quoted in O'Connell, 1998) began to use the method of scaling as they found that clients could use it to express what they had meant, even if the meaning was not clear to anyone else. This enables the therapist to access the degree of progress that the client has already made towards the realisation of the preferred future (George, Iveson & Ratner, 1999; O'Connell, 1998; Sharry, 2001). The therapist uses a scale of zero to ten, with ten representing the morning after the miracle and zero representing the

worst the problem has been. Scaling questions invite clients to range their observations, impressions, and predictions on a scale from 0 to 10 (De Jong & Berg, 1998). The primary purpose of scaling questions is to assist clients in formulating identifiable goals, to measure progress, to establish priorities for action, and to assess client motivation and confidence. They are introduced in the first session and can be used and developed subsequently in sessions to follow (George et al., 1999; O'Connell, 1998; Sharry, 2001; Tohn & Oshlag, 1995).

According to Franklin et al. (1997), studies on the psychometric properties of self-anchored scales (compatible with the scaling technique used in the present study) demonstrate that these scales have acceptable validity and reliability. Self-anchored scales have been referred to in the literature as “target complaint scales”, “individual problem rating scales”, and more recently “individualised rating scales” (Franklin et al., 1997). They are viewed as a clinically sensitive outcome method compatible with single case-designs. Client self anchored scales are compatible with the scaling technique, and provides a flexible method for collecting outcome data (Franklin et al., 1997). Scaling questions enable participants to become aware of their own level of progress and the existence of possible exceptions to their problems. A study made by Franklin et al. (1997), illustrated the clinical utility of using client self-anchored scales in single-case designs for conducting outcome evaluations in Solution-Focused Brief Therapy.

Finding appropriate measures of change that are compatible with the ideographic methods of SFBT, poses a challenge. According to Franklin et al. (1997), SFBT therapists work with the client's cognitive constructions of problems (the viewing) and collaboratively assist clients to formulate small, well-defined, individual and behavioural change goals (the doing). Problems and goals are discussed in terms of the language and meanings of the client and may vary from case to case. This type of approach to therapy requires flexibility and creativity in selecting outcome measures of change because the case-to-case definitions of problems are as unique as different clients' subjective experiences (Franklin et al., 1997).

Global measures of change, such as standardised inventories like the OQ-45.2, may be appropriate for some cases in practice, but might lose pragmatic validity for others due to shifting problem definitions. Authors such as Shuttleworth-Jordan (quoted in Maree, n.d.) draw attention to the current, broader model of psychological testing in which a more holistic approach has become the focus of attention.

2.3 Procedure

A preliminary meeting with all the participants was held at the Eureka Youth Centre a week before the start of the intervention programme. A biographical questionnaire was handed out for completion to the participants in the three treatment groups and in the control group. Due to time limits and a lack of a adequate space for all participants to assemble, participants were alphabetically divided into two groups.

At this point in the research procedure, nobody was aware of who would form part of the experimental and control groups. This preliminary meeting took an hour for each of the two groups, and the second meeting was scheduled to take place immediately after the first.

Participants were motivated to complete the questionnaires, but they raised concern about the confidentiality of the results. They were afraid of ridicule by their peers and that their answers to some of the questions regarding “wellbeing” and “crimes committed and sentenced for”, could be used to influence the duration of their sentences. Consequently, the concept of confidentiality was discussed in great detail. Due to participants’ limited ability to concentrate, as well as the fact that most of them suffered from reading and learning disabilities, the questionnaire was administered by reading the items to participants in both groups.

The intervention sessions started a week after the preliminary meeting. The three experimental groups were seen for four weekly hour-long sessions each, which were scheduled and conducted after one another. All three experimental groups were exposed to the same methods and interventions.

During the separate intervention sessions with each of the three treatment groups, the control group was separated into two groups and assembled in the centre's library. Here they watched educational videos, which were not related to any form of therapeutic intervention.

Intervention began with an initial "icebreaker" exercise. This is a trust- and rapport-building technique that involves participants forming a circle around one blindfolded group member. The blindfolded member is instructed to pretend to be "weightless" and to fall gently backwards and forwards, trusting the rest of the participants to catch him. This exercise was aimed at forming a collaborative relationship, which lasted throughout subsequent sessions. Once the rules and structure of the sessions had been established, participants received instruction regarding the assumptions of the SFBT model. The first session was aimed mainly at assisting participants in creating clear, simple and attainable goals, through defining their presenting problems in a solvable way.

During the first session, the scaling question was introduced with the specific intention of assisting participants in identifying and formulating individualised goals for the realisation of their preferred future, as formulated through the use of the miracle question. This proved to be difficult, because of the participants' use of concrete thinking and their inability to express themselves. Due to the random assignment of participants to control and experimental groups, various gangs were represented in each group. This accounted for a great amount of antagonism, lack of interaction and conflict between group members. It resulted in a lack of confidence and willingness among group members to formulate and share their visions of a preferred future with the rest of the group.

It became apparent that the scaling questions had great utility and versatility. Due to the initial antagonism that was present in the groups, as well as participants' inability to express themselves verbally, scaling questions provided a useful means of accessing their perceptions about their self-esteem, self-confidence, investment in change, the prioritisation of problems to

be solved, and evaluation of progress. The repeated use of the scaling questions, enabled group members to start to express themselves verbally and visually by completing their scales of 0 to 10 toward establishing their goals. Once the essential trust and interaction between group members had been established, it became apparent to participants that they could identify with each other's experiences and a great power of universality was established.

To see the visible improvement in their general mood and confidence in their strengths and potential proved to be a satisfying experience for them. The scaling questions became a useful technique for making complex aspects of these young offenders' lives more concrete and accessible to both the therapist and themselves. In addition, it became an effective alternative tool for measuring their improvement with regard to the quality of their interpersonal relationships, their subjective feelings of discomfort and their general social role and performance of tasks.

Each session was marked by the initial positive diagnostic exploration of each member's problems, followed by the positive education of the subjective feelings of anxiety and depression often accompanying by these problems. The aim was to make sense of the idiosyncratic language that each participant used to describe his own reality.

The next step was to establish participants' goals and expectations of therapy, through the introduction of the miracle question. The miracle question was aimed at identifying participants' existing solutions and resources, and to clarify their goals in realistic terms. The miracle question made it possible for participants to identify one or two main goals, which were mainly related to the absence or the opposite of the problems they discussed at the beginning of the session, namely what life would be like without these problems. As a result, their goals were related to the need to have more satisfying interpersonal relationships, a need to experience fewer feelings of anxiety and depression and to feel more satisfied with their performance of their social role.

Evaluative strategies were used throughout subsequent sessions and involved the reassessment of participants' goals in order to determine a need to alter existing goals in light of recent changes experienced by them. Each session was marked by the identification of exceptions – those times when the problem was not present, or was managed better.

Homework was described to participants as maximising the benefits of what was learned in therapy, instead of placing too much emphasis on prescribing tasks.

The last three sessions ended with constructive feedback to participants, with close attention being given to each participant's response in order to evaluate each one's understanding of what had been discussed during the session. In addition, participant feedback on the week that had passed was asked at the start of each subsequent session, in order to make an assessment of any positive changes experienced, and to amplify it.

The fourth and final session was marked by the termination of intervention. This stage involved the prediction of the possible future occurrence of relapses, and participants were assisted in deciding how to deal with potential obstacles in their progress towards their preferred futures. For a more detailed description of the interventions, see Addendum 1.

In order to assess the effect of intervention on the participants in the experimental group, the OQ-45.2 was again administered to both experimental and control groups after the termination of the fourth and final session. The decision to make this final evaluation immediately after the fourth session was taken for practical reasons, such as the difficulty of contacting participants once they had served their sentences.

The data analysis software system **STATISTICA V 6** (Statistica Enterprise Systems, Technology, n.d.) was used for the analysis of the data in hand. Cronbach Alpha was used as a measure of internal reliability for the multi-item summated rating scales of the three areas of functioning. An acceptable or sufficient value for alpha would be in the range of 0.5 to 0.7 (Kent,

2001). Repeated measures of analysis of variance (**RANOVA**) were used to compare the means of the experimental and control group along the three dimensions, before and after intervention.

3. RESULTS

The calculated statistics obtained from repeated measurements of analysis of variance (RANOVA), suggested that no statistically significant interaction between the experimental and control group had occurred over time for the three variables (Interpersonal relations, $p=0.60$; Subjective discomfort, $p=0.53$; and Social role, $p=0.89$), as measured individually, as well as for total wellbeing (three subscales combined) ($p=0.76$). The results will be discussed in greater detail in the following sections.

3.1 Analysis of Reliability

An analysis of the internal consistency (Cronbach alpha) of the items for the three scales combined, as well as for each scale separately, showed relatively low values ($\alpha < 0.7$), which might have influenced the results. For a more detailed description of these results, see Addendum 2.

3.2 Total Wellbeing

Repeated measures of analysis of variance (RANOVA) were used to determine and compare the impact of intervention and make a comparison between experimental and control groups over time (as measured by the OQ-45.2 for the three subscales combined, i.e. total score). Three analyses are reported in Table 1. Firstly, the degree of interaction for the total score between experimental and control groups, before and after intervention had taken place. It indicates the level of increase or decrease in total mean scores as measured with the OQ-45.2. It indicates whether a change in total score had taken place in the experimental groups over time. Secondly, it displays the difference in means between experimental and control groups for pre- and post-tests combined. This indicates whether experimental and control groups' means are comparable for the total score (as one would expect due to the process of random selection which took place

before intervention). Thirdly, it shows the level of increase or decrease in the means for the total score from pre- to post-intervention for the experimental and control groups combined. This indicates whether a change had taken place in the three scales combined (total score) over a period of time (as a result of time having passed from pre- to post-test intervention). The calculated statistics are shown in Table 1.

Table 1

Wellbeing before and after intervention for the Experimental (n=18) and Control (n=18) groups

Effect	Means	F-value	p-value
Interaction between group (experimental and control) and time (pre-test and post-test)		0.09	0.76
Comparison between experimental and control groups' means for pre- and post-intervention combined	Experimental = 64.90 Control = 75.45	3.06	0.09
Difference in means from pre- to post-intervention for experimental and control groups combined	Pre = 74.12 Post = 66.23	6.23	0.01

It follows from Table 1 that no statistical significant interaction ($p=0.76$) between experimental and control groups had occurred over time for total wellbeing (the summation of the three measured variables as indicated by the total score). Furthermore, the difference in means between experimental and control groups (pre- and post-test combined) were not strictly significantly different on a 5% level. It is, however, significant on a 10% level ($p=0.09$). It also follows from Table 1 that a decrease in the means (improvement) from pre- to post-test had occurred in both the experimental and control groups ($p = 0.01$), but that this decrease cannot be viewed as more significant for the experimental than for the control groups.

Figure 1 displays the means (total wellbeing) for the experimental and control groups before and after intervention

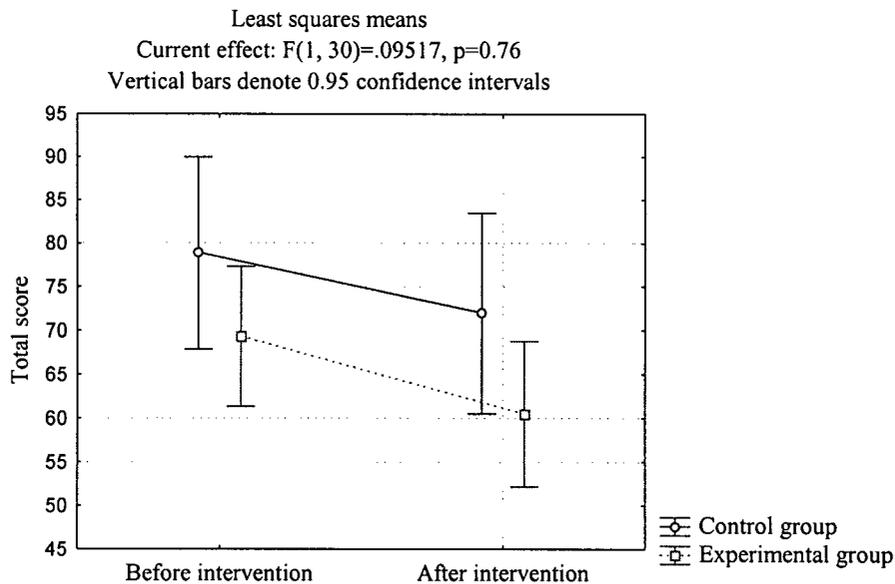


Figure 1. Graph depicting the mean (total wellbeing) for experimental (n = 18) and control (n = 18) groups before and after intervention

It follows from Figure 1 that the decrease in the experimental groups' mean for all three variables combined (Total score) did not appear to be more significant from pre- to post-testing than the decrease in the control groups' mean. Thus, it may be said that no statistically significant interaction between experimental and control groups had occurred over time for the three summated variables ($p=0.76$).

3.3 Interpersonal relationships

Repeated measures of analysis (RANOVA) were used to determine and compare the impact of intervention on the quality of Interpersonal Relationships and to make a comparison between experimental and control groups over time. The calculated statistics in Table 2 are similar to the statistics displayed in Table 1. Firstly, the degree of interaction between the experimental and

control groups for this measured variable before and after intervention that had taken place is displayed. This indicates whether the intervention had an impact on the quality of Interpersonal Relations as a result of the time that had passed from pre- to post-test intervention. Secondly, it displays the difference in means between experimental and control groups for pre- and post-tests combined. This indicates whether experimental and control groups' means are comparable for this measured variable (as one would expect due to the process of random selection which took place before intervention). Thirdly, it shows the level of increase or decrease in the mean Interpersonal Relationships from pre- to post-intervention for the experimental and control groups combined. It indicates whether the quality of Interpersonal Relationships increased more for the experimental groups than for the control groups over time, as a result of the therapeutic intervention. The results are shown in Table 2.

Table 2

Repeated Measures (RANOVA) results for the variable Interpersonal Relationships (n=18)

Effect	Means	F-value	p-value
Interaction between group (experimental and control) and time (pre-test and post-test)		0.28	0.60
Comparison between experimental and control groups' means for pre- and post-intervention combined	Experimental = 14.61 Control = 15.86	0.44	0.51
Difference in means from pre- to post-intervention for experimental and control groups combined	Pre = 15.67 Post = 14.80	0.47	0.49

It follows from Table 2 that the means of the experimental and control groups were not different for pre- and post-intervention combined ($p=0.51$). It also follows from Table 2 that the intervention did not result in a significant difference between the means of the experimental and control groups from pre- to post-intervention ($p=0.60$).

Figure 2 displays the means (interpersonal relations) for the experimental and control groups before and after intervention.

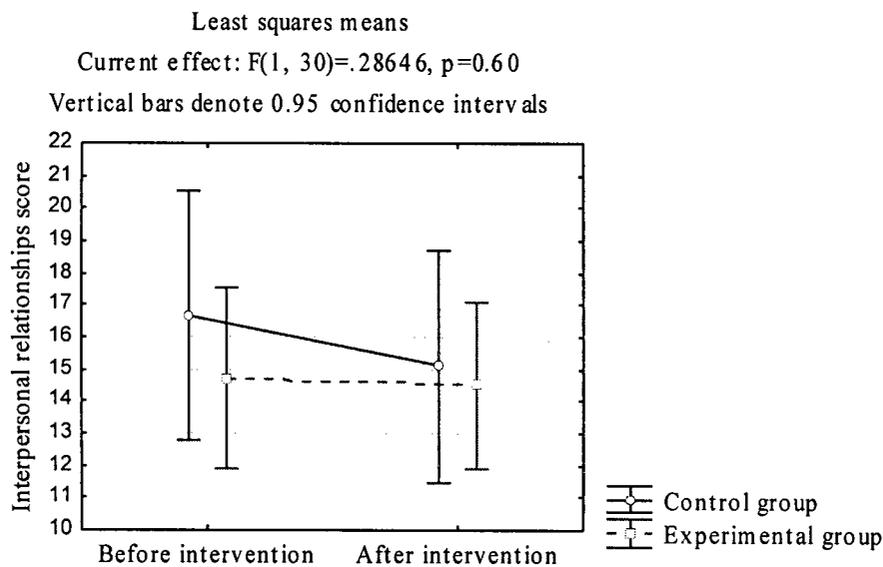


Figure 2. Graph depicting the mean Interpersonal Relations scores for experimental ($n=18$) and control ($n=18$) groups before and after intervention.

From Figure 2 it can be said that no statistically significant interaction on the dimension of Interpersonal Relations between the experimental and control groups had occurred over time ($p=0.60$).

3.4 Subjective Discomfort

In order to evaluate the effect of the intervention on the quality of Subjective Discomfort, as well as to make a comparison between experimental and control groups over time, repeated measures of analysis (RANOVA) were used. The calculated statistics in Table 3 is similar to the statistics displayed in previous tables.

Firstly, it displays the degree of interaction between the experimental and the control groups on this measured variable (subjective discomfort), before and after intervention had taken place. This indicates whether the intervention had an impact on the levels of Subjective Discomfort as a result of the time that had passed from pre- to post-test intervention.

Secondly, it displays the difference in means between experimental and control groups for pre- and post-tests combined. This indicates whether experimental and control groups' means are comparable for this measured variable (as one would expect due to the process of random selection which took place before intervention).

Thirdly, it shows the level of increase or decrease in the mean Subjective Discomfort from pre- to post-intervention for the experimental and control groups combined. It indicates whether the levels of Subjective Discomfort decreased more for the experimental groups than for the control groups over time, as a result of the therapeutic intervention. The results are shown in Table 3.

Table 3

Repeated Measures (RANOVA) results for the variable Subjective Discomfort (n=18)

Effect	Means	F-value	p-value
Interaction between group (experimental and control) and time (pre-test and post-test)		0.40	0.53
Comparison between experimental and control group means for pre- and post-intervention combined	Experimental = 38.95 Control= 45.40	3.13	0.08
Difference in means from pre- to post-intervention for experimental and control groups combined	Pre= 44.98 Post= 39.37	5.51	0.02

Table 3 shows that the difference in means between experimental and control groups (pre- and post-test combined) were not strictly significantly different on a 5% significance level. It was significant however, on a 10% level ($p=0.08$). It also follows from Table 3 that a decrease in the means from pre- to post-test had occurred in both the experimental and control groups ($p=0.02$), and that the experimental group mean decreased more from pre-to post test, than the mean of the control group (see Figure 3). However, this decrease cannot be viewed as statistically significant.

Figure 3 displays the means (subjective discomfort) for the experimental and control groups before and after intervention.

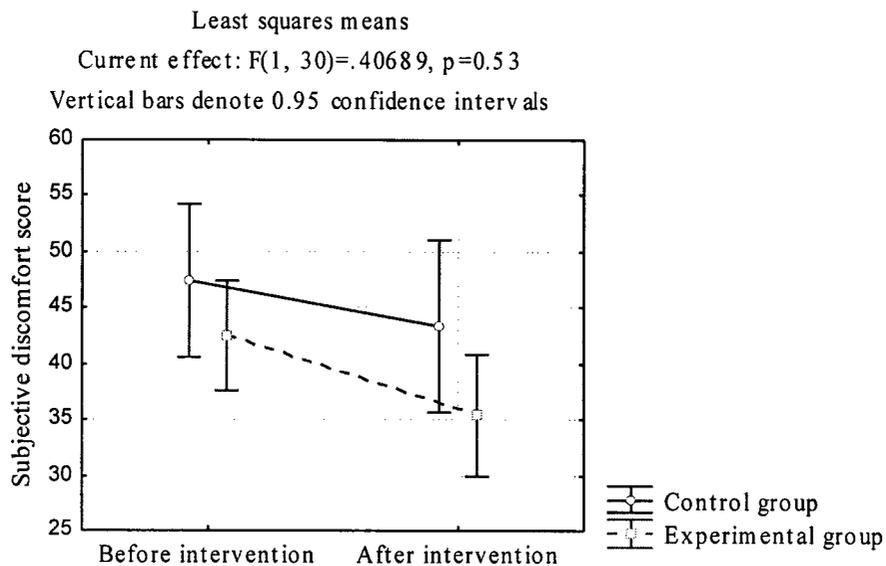


Figure 3. Graph depicting the mean Subjective Discomfort scores for experimental (n=18) and control groups (n=18) before and after intervention.

From Figure 3 it appears that there was a small degree of interaction in the sense that the experimental groups' mean decreased more from pre- to post-testing, than did the mean of the control groups. This interaction, however, is not statistically significant ($p = 0.53$).

3.5 Social Role Performance

In order to determine the effect of the intervention on the quality of Social Role Performance, repeated measures of analysis (RANOVA) were used. The calculated statistics displayed in Table 4 is similar to the statistics shown in previous tables. Firstly, it displays the degree of interaction between the experimental and control groups on this measured variable (Social Role Performance), before and after intervention took place. This indicate whether the intervention had an impact on the quality of Social Role Performance as a result of the time that had passed from pre- to post-test intervention. Secondly, it displays the difference in means between experimental and control groups for pre- and post-tests combined. This indicates whether experimental and control groups' means are comparable for this measured variable (as one

would expect due to the process of random selection which took place before intervention). Thirdly, it shows the level of increase or decrease in the mean Social Role Performance from pre- to post-intervention for the experimental and control groups combined. It indicates whether the quality of Social Role Performance increased more for the experimental groups than for the control groups over time, as a result of the therapeutic intervention. The results are shown in Table 4.

Table 4

Repeated Measures (RANOVA) results for the variable Social Role Performance (n=18)

Effect	Means	F-value	p-value
Interaction between group (experimental and control) and time (pre-test and post-test)		0.01	0.89
Comparison between experimental and control groups' means for pre- and post-intervention combined	Experimental = 38.95 Control = 45.40	4.81	0.03
Difference in means from pre- to post-intervention for experimental and control groups combined	Pre = 44.98 Post = 39.37	2.44	0.12

Table 4 shows that no statistically significant interaction had occurred between the experimental and control groups on the dimension of Social Role Performance after intervention ($p=0.89$). It follows from Table 4 that the means of the experimental and control groups were significantly different for pre- and post-test combined ($p=0.03$). Table 4 also indicates that both the experimental and control groups displayed a decrease in the measured variable from pre- to post-testing ($p=0.12$), although not statistically significant.

Figure 4 displays a graphical presentation of the means (Social Role Performance) for the experimental and control groups before and after intervention.

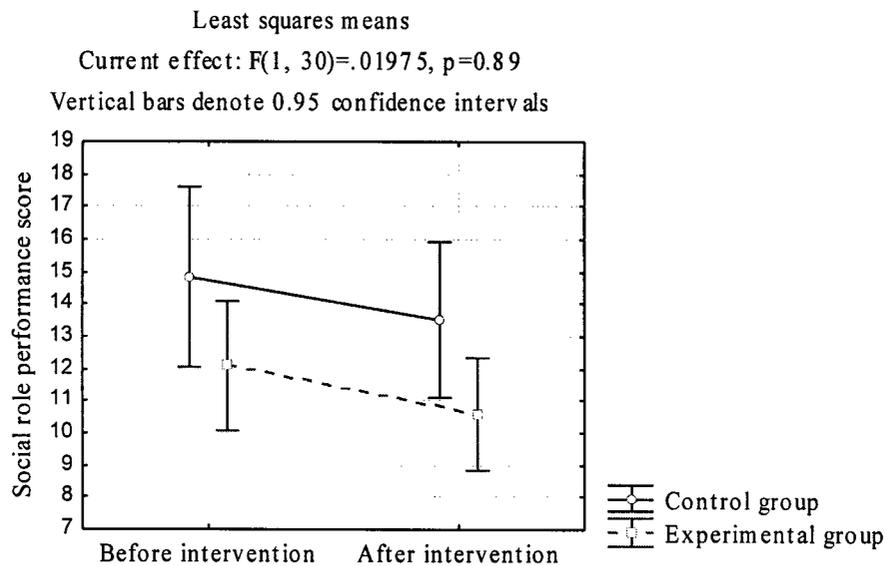


Figure 4. Graph depicting the mean Social Role Performance scores for the experimental (n=18) and control (n=18) groups before and after intervention

According to the results displayed in Figure 4, the means of the variable Social Roles, suggest that no statistically significant interaction had occurred over time between the experimental and control groups ($p=0.89$).

3.6 Scaling questions

Participants' responses to the **scaling questions** throughout each of the four therapeutic intervention sessions contributed towards highlighting certain recovery factors and confirmed personal progress along the dimensions. The scaling questions were used to determine participants' perception of their progress towards their personalised goals and the realisation of their preferred future, as identified by means of the miracle question. These goals are based on

their belief in their potential to overcome the various difficulties they are faced with. Examples of personalised goals as formulated by participants are as follows:

- To feel happy: i.e. to experience a lesser amount of distress as a result of “bad” choices such as involvement in gangs, drugs, theft and other crimes
- To find a “proper and decent job” and to provide financial security for their families
- To achieve something in life and to not be labelled as a criminal for the rest of their lives
- To improve their relationships with their families and friends
- To be able to “communicate better” and “to not get angry so often” i.e. be more assertive and less aggressive
- To be able to “change their lives for the better” i.e. to stop using drugs and involvement in gangs and organised crime
- To achieve self-confidence and to exercise self-discipline
- To learn to trust
- To be able to “handle problems better” i.e. to be more positive and less negative about themselves, others and their future
- To be able to respect themselves and others

All participants identified one primary goal, whereas the majority (n=10) specified a second goal. The results of their perceived progress towards these goals can be seen in Figures 5 and 6.

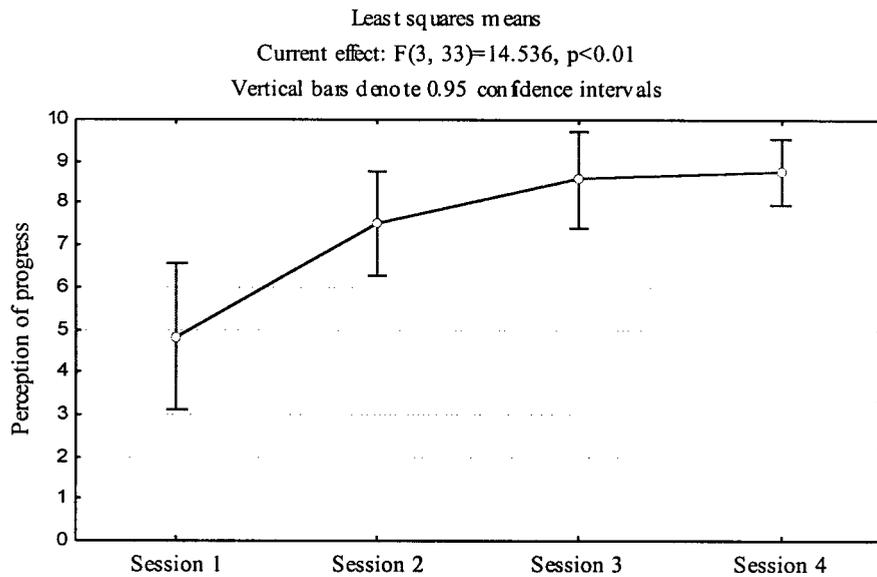


Figure 5. Graph depicting mean progress towards personalised goal one over time (n=18)

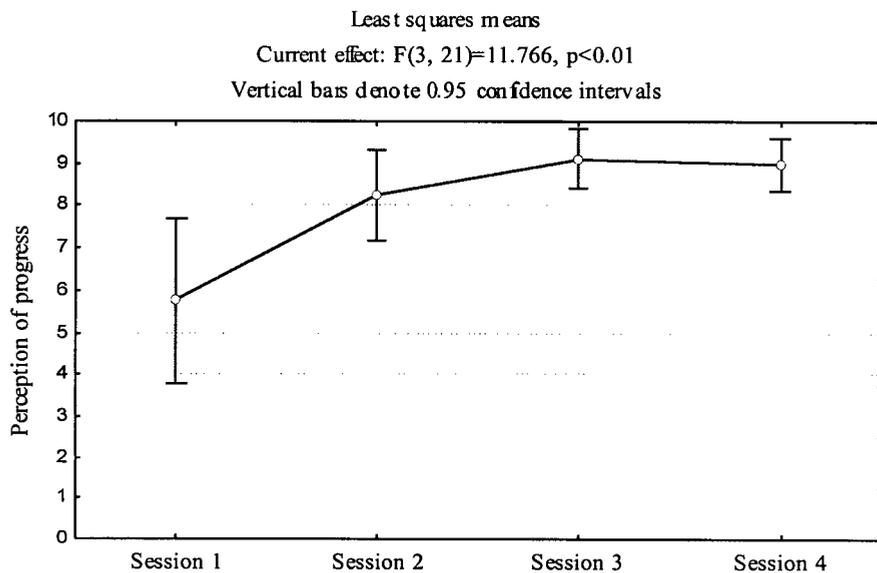


Figure 6. Graph depicting mean progress towards personalised goal two over time (n=10)

It is evident from Figures 5 and 6 that significant improvement towards these goals had occurred over time. Improvement seems to be rapid at first, followed by a slightly slower rate of improvement and subsequent stabilisation. These results suggest a significant improvement in participants' belief in their strengths and competency to achieve their various individualised goals.

4. DISCUSSIONS AND CONCLUSION

The aim of this project was to evaluate the effectiveness of Solution-Focused Brief Therapy in a South African Youth Centre for young offenders. The research question was whether Solution-Focused Brief Therapy can be regarded as an effective intervention method to reduce young offenders' symptomatic distress, increase the quality of their interpersonal relationships, and improve their functioning in social roles and life tasks. Two measures were used in order to assess the impact of the therapeutic intervention. These different methods presented different results.

According to the results of the OQ-45.2, no statistically significant improvement occurred in either the experimental or the control groups on the three dimensions of interpersonal relations, subjective discomfort, and social role performance after intervention. However, there appeared to be a small degree of interaction between experimental and control groups on the dimension of subjective discomfort, in the sense that the experimental group mean decreased more (an improvement), from pre- to post-testing, than the mean of the control group. This interaction, however, is not statistically significant ($p=0.52$). In addition, it appeared that both experimental and control group experienced an improvement on the dimension of Subjective Discomfort. It does not follow from the analysis, however, that this improvement was statistically more significant for the experimental groups than it was for the control group.

A possible explanation for this occurrence could be found in the Hawthorne effect. This effect occurs when the mere existence of a research project and the attention that participants receive, regardless of whether they belong to the experimental or control group, could lead to improvement, such as revealed by the three domains of functioning measured in the present study.

From the results obtained with the OQ-45.2, the deduction could be made that Solution-Focused Brief Therapy can not be regarded as an effective intervention method for reducing young offenders' symptomatic distress, increase the quality of their interpersonal relationships, as well as improving their functioning in social roles and life tasks. However, the reliability of the OQ-45.2 in this study (Cronbach Alpha) should be taken into consideration before one decides not to reject the null hypotheses. Cronbach Alpha for the three sub-scales showed relatively low values ($\alpha < 0.7$). Although the Cronbach Alpha is slightly higher for the measured variable Subjective Discomfort (0.73 before intervention and 0.81 after intervention for groups combined), the overall results suggested the existence of a slightly less than minimum acceptable level of reliability, which might have blurred the results.

Although the OQ-45-2 is a standardised instrument and the internal consistency was found to be high (Lambert et al., 1997), in light of the calculated coefficients for this study, the relatively low values of the Cronbach Alpha could be ascribed to participants' lack of comprehension of the questions due to reading difficulties and limited ability to concentrate. As the OQ-45.2 was administered on only two occasions (once before intervention started and once after the last intervention session), one must consider that important changes (which might have occurred during intervention) could have gone undetected. Therefore, measuring possible change on many different occasions, including during the course of therapy might be an asset (Mueller et al., 1998).

During the course of the intervention sessions, possible change was also measured by means of data obtained from scaling questions, which proved to be an effective measure of outcome data (Franklin et al., 1997). The use of a brief self-report questionnaire (such as the OQ-45.2 in this study) can hardly be seen as a sufficient method for understanding complex dimensions such as interpersonal relationships, subjective discomfort and social role performance. It is important that other methods for measuring change should also be explored (Lambert et al., 1998).

Despite the hindrance of missing data, and limited concentration and literacy on the part of participants, significant indications regarding participant progress were actually determined. Observations based on non-standardised descriptive data reflect a more complete picture of the three areas of functioning explored in this study. Participants' responses to the **scaling questions** throughout each of the four intervention sessions contributed towards highlighting certain recovery factors and confirmed progress along the dimensions (see Figures 5 and 6).

The introduction of the miracle question enabled participants to identify their solutions and resources in relation to their current problems and to clarify their goals in realistic terms. The majority of participants (n=10) had two main goals, which were related to the absence or opposite of the problems they had discussed at the beginning of the first session. Figures 5 and 6 display participants' perceived progress towards their personalised goals. It follows from these results that participants had experienced rapid improvement towards these goals at first, with slight stabilisation towards the end of therapeutic intervention. These results seem to reflect a more complete picture of the three areas of functioning explored in this study. Participants' identified goals, as highlighted by the miracle question, appeared to be in relation to the three areas of functioning.

Examples of personalised goals related to the area of interpersonal relationship functioning, were: the need to improve relations with their families and friends; to be able to respect others and themselves; and to be more assertive and less aggressive in their relationships with others.

Throughout the therapeutic intervention, participants came to improve their coping skills with regard to conflict resolution and assertiveness. According to Sharry (2001), a group setting provides an excellent opportunity for interpersonal learning, as participants gain insights into their relationships with others both by relating differently themselves, and by observing from others how to relate. In this solution-focused group setting, the focus was on positive patterns of

communication in the groups, which can, as Sharry (2001) states, directly lead to the enhancement of interpersonal learning.

According to the results displayed in Figures 5 and 6, the assumption could therefore be made that participants' gradual progression towards the mentioned individualised goals, is an indirect indication of significant improvement in their levels of interpersonal relationship functioning.

Participants came to realise that they tend to experience symptoms of anxiety and depression from time to time and that different members have different ways of expressing these subjective feelings of discomfort. In using scaling questions, participants were able to express complex, intuitive observations about their past experiences and feelings of subjective discomfort (De Jong & Berg, 1998). They could use their own language, meanings and experiences to construct their individual goals in relation to the area of subjective discomfort. Examples of personalised goals formulated by participants in relation to the dimension of subjective discomfort was to feel "happy", e.g. to experience less distress about bad choices such as involvement in gangs, drugs, theft and other crimes; as well as to be able to handle problems better, e.g. to be more positive and less negative about themselves and others, their world as they experience it and their future. According to the results displayed in Figures 5 and 6, a significant improvement towards these goals had occurred over time.

It became clear during the therapeutic interventions that participants experienced a great amount of dissatisfaction, conflict and distress in their school tasks, the roles they play within their family settings and society and the tasks they perform during their leisure time. According to participants' feedback, their approach to their school tasks is influenced by their view of themselves as failures and by the rejection of their friends and families, due to the stigma of being a youth offender. Many participants struggle at school and fail to ask for assistance from their teachers not wanting them to think they are "slow" or "stupid".

In reaction to the Miracle Question, participants identified personalised goals, which were in relation to the dimension of social role performance. Examples of the goals formulated by them in relation to this dimension of social role performance were: to find a “proper and decent job” and to fulfil the role of the provider of their families; to achieve something in life and not be labelled as a criminal for the rest of their lives; and to be able to “change their lives for the better”, i.e. to stop using drugs and involvement in gangs and organised crime. During the therapeutic intervention, participants came to improve their skills and increase their belief in their potential to fulfil these roles in future. According to the results displayed in Figures 5 and 6, a significant improvement towards these goals occurred over time.

According to Cade and O’Hanlon, (quoted in Franklin et al., 1997), Solution-Focused Brief Therapy is one of the most interesting and promising developments in the field of brief therapy over the last decade. Various methods of this therapy are continually being refined towards clearer descriptions of what constitutes effective psychotherapy. Several uncontrolled case reports and a few controlled case and outcome studies are starting to emerge, generally supporting the effectiveness of SFBT. However, more studies and effective methods for collecting outcome data are needed (Franklin et al., 1997) and the effectiveness of self- anchored scales, as a method of collecting outcome data in group therapy, must be explored.

A methodological challenge in the measurement of outcome in this study was the brevity of therapy, with limited time to collect systematic information from the participants. In addition, it has proved to be very difficult to conduct follow-up calls as a means of finding out whether movement towards the preferred future has remained intact. A significant methodological challenge for the future would be to use a research design that takes into account the variation in SFBT cases based on their various individualised needs and individual differences. This proved to be a limitation in this study, as each participant was unique and the stated goals were very different. In addition, finding measures that are brief, valid, reliable, and clinically sensitive to

rapid shifts in clients' perceptions and experience of change, proves to be difficult (Franklin et al., 1997). Considering these challenges, it seems logical to explore methods for expanding the scaling technique and developing additional techniques in order to track outcomes in SFBT.

This study demonstrated the positive impact of Solution-Focused Brief Therapy as a brief form of intervention in the lives of young offenders. It encourages therapists and researchers to explore the utility and the effectiveness of Solution-Focused Brief Therapy for constructing change, and to develop effective ways to monitor outcome results with Solution-Focused Brief Therapy.

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ADDENDUM A

Session 1 began with an initial trust and rapport-building technique—an “icebreaker” exercise aimed at the formation of a collaborative relationship. This collaborative relationship lasted throughout subsequent sessions. Once everyone was acquainted and comfortable, each member was asked the following question: “If you are asked by someone you don’t know to describe your strengths and positive attributes, what will you tell him?”

This technique created a climate for change and enabled the therapist to show an interest in the client as a person instead of viewing him as the problem he is presenting. According to De Jong and Berg (in Miller & Duncan, 2000) the purpose of these questions are to initiate examples of the client’s coping strategies, strengths and resources. Once the concept of confidentiality, the rules and structure of the next sessions had been established, participants were educated regarding the assumptions of the SFBT model.

The first session was marked by exploring each member’s problem in a positive diagnostic way. This was aimed at allowing each participant to describe his reality in his own idiosyncratic language. In addition, this was done in order to prevent participants from being under the impression that their pain was minimised. This is a danger that can exist if the impression is unknowingly given that the client is only permitted to engage in solution talk (Miller & Duncan, 2000). The therapist aimed at trying to understand the client’s frame of reference and perceptions and aimed to understand the client’s unique experience of the problem. The power of language was used to deconstruct the problem and to encourage scepticism in clients about the labels that had been ascribed to them over the years. Although having a diagnosis can be a source of relief and reassurance in certain circumstances, these labels can result in a self-fulfilling prescription (O’Connell, 1998).

Throughout following sessions, two techniques were used to deconstruct the problem: Reframing, which entailed the provision of an alternative perspective on the problem, changing the conceptual and / or emotional viewpoint of the experience, and Externalisation, a way of viewing the problem as being external and not located within the person. It offered a different perspective from which participants viewed their problems and allowed for the possibility of shifting their attitudes towards it (O'Connell, 1998).

Time for psycho-education was allocated during each session. This involved the explanation of symptoms of anxiety and depression in a positive educational way, as people are often misinformed regarding their own feelings about their problems. This was done under the assumption that it might stabilise the system responsible for maintaining the problem (Tohn & Oshlag, 1995).

The first session was aimed mainly at assisting participants in creating clear, simple and attainable goals, by defining their presenting problems in a solvable way. This was done by introducing the miracle question, which was aimed at identifying participants' existing solutions and resources, and clarifying their goals in realistic terms. In addition, it involved the identification and modification of utopian and unrealistic "all or nothing goals" to more realistic and attainable goals. This was a central part of intervention, as goals are viewed as the motivators for change. Throughout subsequent sessions, participants' goals were reassessed through evaluative strategies. This was done, due to the tendency that participants experience change and existing goals therefore need to be altered as a result.

After the establishment of participants' goals and expectations of therapy, this future-orientated question (miracle question) was revisited throughout subsequent sessions, which were aimed at assisting participants to describe what life will be like once the problem had been solved or was managed better. This enabled the assessment of old utopian goals, as well as the formulation of new, realistic short- and long-term goals throughout the treatment programme.

The purpose of the miracle question was to generate a rich, detailed and practical description of life without the problem, as well as to explore the unique strategies that participants would adopt to change their problematic behaviour throughout intervention.

The scaling question was introduced during the first session, after participants had established their personalised goals for their preferred future. This question was aimed at enabling participants to become aware of their own levels of stimulation, progress towards and belief in their personalised goals. This technique was used throughout subsequent sessions in order to measure progress and to establish priorities for action, as well as to assess participants' motivation and confidence. It was aimed at accessing the degree of progress participants had already made towards the realisation of their preferred future (George et al., 1999) and to try to find ways by which these changes could be maintained and amplified. It was also used as an unstandardised measurement of progress towards personalised goals and to determine the next small step in treatment for each individual participant.

Each session was marked by the identification of exceptions. Exceptions are those times when the problem was not present or was managed better. Based on the assumption that constant description of presenting problems are not a useful resource for building solutions, participants were asked to focus on possible exceptions to their problems (O'Connell, 1998). Exceptions provide a glimpse of what the future could be like and provide clues for tracking solutions and resources, as well as for disregarding failed solutions. By exploring exceptions, participants were enabled to become increasingly aware of their current and past successes in relation to their goals (Miller & Duncan, 2000).

Homework was described to participants as maximising the benefits of what was learned in therapy. Solution-focused therapists vary with regard to the importance they attach to giving homework and inviting clients to report on the tasks they have attempted between sessions. Due to the majority of participants having a negative connotation of homework, minimum emphasis

was placed on viewing this as a central part of therapy and of prescribing tasks, but rather describing it as a means to continue progress already made and to look out for any small changes or signs of change.

All four sessions ended with constructive feedback to participants, with close attention being given to each participant's response in order to evaluate their understanding. Participant feedback at the end of each session was viewed as an opportunity to conceptualise problems that were identified during feedback and either to intervene immediately or to include this as part of the agenda for the next session. In addition, participant feedback on the week that had passed was requested at the start of the second and third sessions in order to assess for any positive changes experienced and to amplify it. Any progress or small changes that were made were amplified and any failures were identified as learning experiences.

Participants were asked to identify what they had learned from each failure and to separate difficulties into two groups: a) Those they could change and b), those they could not do anything about. Participants were asked what they should do differently in order to cope with both types of difficulties. The following question was asked regarding situations beyond their ability to change: "How will you be feeling differently toward this situation?" Participants were asked to consider how they would maintain continued progress towards their goals, by presenting the following question: "How will your life be different now?" This was also used as an opportunity to start preparation for termination. Participants were warned against possible setbacks, and reminded that failure could provide opportunities for further learning and insight into their situation. Within the Solution-Focused therapy model, the ending of therapy should be on the agenda right from the start of therapy. According to O'Connell (1998), the therapist should aim to remove him/herself from the client's life as soon as possible, due to the danger of dependency and loss of focus in the therapy process.

The fourth and final session was marked by the termination of treatment. This stage in the intervention involved the prediction of the possible occurrence of relapses in the future, and participants were assisted in deciding to deal with potential obstacles to progress towards their preferred future. In situations where participants experienced rapid changes (which could be distressing for significant others or themselves), they were cautioned against changing too fast and advised to adapt to the changes they experience.

In cases where some participants were concerned that previous anxiety, depression or problematic behaviour could re-occur; relapse prescription was employed as a paradoxical technique in an ongoing behavioural assignment. Participants were instructed to choose a time of day to deliberately and spontaneously allow these symptoms to return. This was based on the assumption that once they tried to allow symptoms to return spontaneously, this would short-circuit the maintenance of the symptom, as this would no longer be a spontaneous act.

ADDENDUM B

Cronbach Alpha for experimental and control groups combined:

Interpersonal Relationships (before)	0.49
Interpersonal Relationships (after)	0.55
Subjective Discomfort (before)	0.73
Subjective Discomfort (after)	0.81
Social Role Performance (before)	0.54
Social Role Performance (after)	0.34

Cronbach Alpha for experimental and control groups separately:

Interpersonal Relationships: control (before)	0.62
Interpersonal Relationships: experimental (before)	0.37
Interpersonal Relationships: control (after)	0.75
Interpersonal Relationships: experimental (after)	0.32
Subjective Discomfort: control (before)	0.77
Subjective Discomfort: experimental (before)	0.70
Subjective Discomfort: control (after)	0.87
Subjective Discomfort: experimental (after)	0.72
Social Role Performance: control (before)	0.58
Social Role Performance: experimental (before)	0.48
Social Role Performance: control (after)	0.10
Social Role Performance: experimental (after)	0.34

ADDENDUM C

OUTCOME QUESTIONNAIRE (OQ-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.	Name: _____ Date: _____	Age: _____ yrs Sex M <input type="checkbox"/> F <input type="checkbox"/>
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	Never	Rarely	Some- times	Frequ- ently	Almost always	SD	IR	SR
1 I get along well with others	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
2 I tire quickly	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
3 I feel no interest in things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
4 I feel stressed at work/school	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
5 I blame myself for things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
6 I feel irritated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
7 I feel unhappy in my marriage/significant relationship	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
8 I have thoughts of ending my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
9 I feel weak	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
10 I feel fearful	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
11 After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark 'never')	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
12 I find my work/school satisfying	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
13 I am a happy person	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
14 I work/study too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
15 I feel worthless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
16 I am concerned about family troubles	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
17 I have an unfulfilling sex life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
18 I feel lonely	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
19 I have frequent arguments	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
20 I feel loved and wanted	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
21 I enjoy my spare time	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
22 I have difficulty concentrating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
23 I feel hopeless about the future	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
24 I like myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
25 Disturbing thoughts come into my mind that I cannot get rid of	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
26 I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark 'never')	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
27 I have an upset stomach	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
28 I am not working/studying as well as I used to	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
29 My heart pounds too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
30 I have trouble getting along with friends and close acquaintances	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
31 I am satisfied with my life	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
32 I have trouble at work/school because of drinking or drug use (If not applicable, mark 'never')	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
33 I feel that something bad is going to happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
34 I have sore muscles	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
35 I feel afraid of open spaces, or driving, or being on buses, subways, and so forth	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
36 I feel nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
37 I feel my love relationships are full and complete	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
38 I feel that I am not doing well at work/school	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
39 I have too many disagreements at work/school	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
40 I feel something is wrong with my mind	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
41 I have trouble falling asleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
42 I feel blue	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
43 I am satisfied with my relationships with others	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
44 I feel angry enough at work/school to do something I may regret	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
45 I have headaches	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			

ADDENDUM D**UITKOMSTE-VRAELYS (UV-45.2)**

Instruksies: Dink terug aan die afgelope week, insluitend vandag, en help ons om te verstaan hoe jy voel. Lees elke item aandagtig en merk die blokkie onder elke kategorie wat jou posisie die beste beskryf. Vir die doeleindes van hierdie vraelys word werk gedefinieer as om 'n vaste werk te hê, skoolgaan, huiswerk, vrywillige werk, ensovoorts.	Naam: _____	Ouderdom _____ jr
	Datum: _____	Geslag M V

	Nooit	Selde	Som-tyds	Dik-wels	Omtrent altyd	SD	IR	SR
1 Ek kom goed met ander oor die weg.	4	3	2	1	0			
2 Ek word gou moeg.	0	1	2	3	4			
3 Ek stel nie in dinge belang nie.	0	1	2	3	4			
4 Ek voel gespanne by die werk/skool.	0	1	2	3	4			
5 Ek blameer myself vir dinge wat gebeur.	0	1	2	3	4			
6 Ek voel geïrriteer.	0	1	2	3	4			
7 Ek voel ongelukkig in my huwelik/belangrike verhouding.	0	1	2	3	4			
8 Ek dink daaraan om my lewe te beëindig.	0	1	2	3	4			
9 Ek voel swak.	0	1	2	3	4			
10 Ek voel angstig.	0	1	2	3	4			
11 Wanneer ek baie gedrink het, het ek die volgende oggend 'n drankie nodig om aan die gang te kom. (As jy nie drink nie, merk "nooit").	0	1	2	3	4			
12 Ek ervaar my werk/skool as bevredigend.	4	3	2	1	0			
13 Ek is 'n gelukkige mens.	4	3	2	1	0			
14 Ek werk/studeer te hard.	0	1	2	3	4			
15 Ek voel nikswerd.	0	1	2	3	4			
16 Ek is bekommerd oor probleme in my gesin.	0	1	2	3	4			
17 Ek het 'n onbevredigende sekslewe.	0	1	2	3	4			
18 Ek voel eensaam.	0	1	2	3	4			
19 Ek maak dikwels rusie.	0	1	2	3	4			
20 Ek voel mense is lief vir my en het my nodig.	4	3	2	1	0			
21 Ek geniet my vrye tyd.	4	3	2	1	0			
22 Ek sukkel om te konsentreer.	0	1	2	3	4			
23 Ek voel wanhopig oor die toekoms.	0	1	2	3	4			
24 Ek hou van myself.	4	3	2	1	0			
25 Ek kry verontrustende gedagtes waarvan ek nie weer ontslae kan raak nie.	0	1	2	3	4			
26 Ek vererg my as mense my drinkgewoontes (of dwelmgebruik) kritiseer. (Indien nie van toepassing nie, merk "nooit".)	0	1	2	3	4			
27 Ek het 'n omgekrapte maag.	0	1	2	3	4			
28 Ek werk/studeer nie so goed soos gewoonlik nie.	0	1	2	3	4			
29 Ek kry baie dikwels hartkloppings.	0	1	2	3	4			
30 Ek sukkel om met vriende en goeie kennisse oor die weg te kom.	0	1	2	3	4			
31 Ek is tevrede met my lewe.	4	3	2	1	0			
32 Ek het probleme by die werk/skool as gevolg van my gebruik van drank of dwelms. (Indien nie van toepassing nie, merk "nooit".)	0	1	2	3	4			
33 Dit voel vir my asof iets ergs gaan gebeur.	0	1	2	3	4			
34 My spiere is seer.	0	1	2	3	4			
35 Ek is bang vir oop ruimtes, of motorbestuur, of om in 'n bus te ry, of vir tonnels.	0	1	2	3	4			
36 Ek voel senuagtig.	0	1	2	3	4			
37 Ek beleef my liefdesverhoudings as voldoende en bevredigend.	4	3	2	1	0			
38 Ek dink nie ek vaar goed in my werk/op skool nie.	0	1	2	3	4			
39 Ek het te veel misverstande by die werk/skool	0	1	2	3	4			
40 Ek dink daar is iets met my kop verkeerd.	0	1	2	3	4			
41 Ek sukkel om aan die slaap te raak of om deur te slaap.	0	1	2	3	4			
42 Ek voel bedruk.	0	1	2	3	4			
43 Ek is tevrede met my verhoudinge met ander.	4	3	2	1	0			
44 Ek voel kwaad genoeg by die werk/skool om iets te doen wat ek dalk later gaan berou.	0	1	2	3	4			
45 Ek kry dikwels hoofpyn.	0	1	2	3	4			

ADDENDUM E

**EUREKA YOUTH CENTRE
BIOGRAPHICAL QUESTIONNAIRE**

STRICTLY CONFIDENTIAL

PLEASE COMPLETE THE FOLLOWING QUESTIONS OR MAKE A ✓ WHERE APPLICABLE

1. Bureau number.....

2. Age.....

3. What is your home language?

- English
- Afrikaans
- IsiXhosa
- Other

4. Race

- Black
- White
- Coloured
- Indian
- Other

5. Highest level of education?

None	Sub	Sub	Std									
	A	B	1	2	3	4	5	6	7	8	9	10
	Gr											
	1	2	3	4	5	6	7	8	9	10	11	12

6. Do you have any other qualifications?

Yes No

If "Yes", please elaborate.....

7. Length of sentence?.....

8. Do you have a confirmed address? Yes No

9. If "Yes", with whom will you stay after your release?

Family

Friends

Employer

Strangers

10. For what type of crime are you sentenced?

Economy

Aggression

Sexual

Drugs

Other

11. From which area do you come from?

Rural

Urban

12. WHICH OF THE FOLLOWING CREATES STRESS IN YOUR LIFE

Loneliness			Uncertainty about the future
Strange culture			Sexual relationship
Physical distance from relatives			Finances
Physical distance from friends			Job uncertainty

13. WHAT WILL YOU DESCRIBE AS YOUR BEST QUALITIES?

- 1.....
- 2.....
- 3.....

Thank you for your co-operation!

ADDENDUM F

**EUREKA JEUGSENTRUM
BIOGRAFIESE GEGEWENS**

STRENG VERTROULIK

VOLTOOI ASSEBLIEF DIE VOLGENDE VRAE OF MAAK SLEGS 'N ✓ WAAR VAN TOEPASSING

1. Raad nommer.....

2. Ouderdom.....

3. Wat is u huistaal?

English

Afrikaans

IsiXhosa

Ander

4. Ras

Swart

Blank

Gekleurd

Indiër

Ander

5. U hoogste skool kwalifikasie?

Geen	Sub A Gr 1	Sub B Gr 2	St 1 Gr 3	St 2 Gr 4	St 3 Gr 5	St 4 Gr 6	St 5 Gr 7	St 6 Gr 8	St 7 Gr 9	St 8 Gr 10	St 9 Gr 11	St 10 Gr 12
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6. Het u enige ander kwalifikasies behaal?

Ja Nee

Indien "Ja", gee asseblief besonderhede.....

7. Datum van vonnis /Lengte van vonnis

8. Het jy reeds 'n bevestigde address? Ja Nee

9. Indien ja, by wie sal u bly na vrylating?

Familie

Vriende

Werkgewer

Onbekendes

10. Vir watter tipe misdaad is u gevonniss?

Ekonomies

Aggressief

Seksueel

Dwelms

Ander

11. In watter omgewing is u woonagtig?

Platteland

Stad

12. WATTER VAN GENOEMDE FAKTORE VEROORSAAK SPANNING IN U LEWE?

Alleenheid

Vreemde kultuur

Fisiese afstand vanaf familie

Fisiese afstand vanaf vriende



Onsekerheid oor toekoms

Seksuele verhouding

Finansies

Werksonsekerheid



13. WAT SOU U BESKRYF AS U BESTE EIENSKAPPE?

- 1.....
- 2.....
- 3.....

Baie dankie vir u samewerking !