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## THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT

Martha C. Hinchey  
*University of Kentucky*, [martha.hinchey@gmail.com](mailto:martha.hinchey@gmail.com)

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Martha C. Hinchey, Student

Dr. H. Thompson Prout, Major Professor

Dr. Kenneth Tyler, Director of Graduate Studies

THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT)  
WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT

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DISSERTATION

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A dissertation submitted in partial fulfillment of the  
requirements for the degree of Doctor of Philosophy in the  
College of Education  
at the University of Kentucky

By

Martha Cord Hinchey

Lexington, Kentucky

Director: Dr. H. Thompson Prout, Professor of School Psychology

Lexington, Kentucky

2015

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## ABSTRACT OF DISSERTATION

### THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT

Research indicates the potential utility of schools as sites for service delivery of mental health interventions. The application of solution-focused brief therapy (SFBT) within the school domain is reflected in the child psychotherapy literature. Findings on the use of SFBT in school settings suggest that it may be well suited to school contexts given its time-efficient, goal-directed, and strengths-based behavioral approach.

The primary purpose of this study was to determine the effectiveness of SFBT with at-risk youth in an alternative school setting. The researcher utilized a multiple case study design to examine the impact of a 6-session SFBT intervention on adolescent behavioral outcomes. Six students were randomized to one of three baseline conditions and received the SFBT intervention following baseline data collection. Data were obtained from multiple raters at baseline, posttest, and 6-week follow-up. In addition, students completed self-reported ratings at the beginning of each SFBT intervention session. Data were evaluated using non-regression approaches and visual analyses.

Preliminary results indicated that four out of six students exhibited reliable change (6-point increase in post-ORS mean scores), and four out of the six students demonstrated clinically significant change (baseline ORS mean scores below the adolescent clinical cutoff of <28). Results also indicated a decrease in total problem behavior scores at posttest for all informants on a normed assessment of emotional and behavioral functioning. Follow-up data were collected for four out of six students, and results suggested that this decrease in ratings was maintained or decreased further across all raters for three out of the four student participants. Overall, preliminary results indicated the potential utility of SFBT with at-risk youth in an alternative school environment. Strengths and limitations of the current study, as well as additional research aims (e.g., impact of therapist alliance, fidelity monitoring in SFBT) and future research areas are also presented.

KEYWORDS: Solution-Focused Brief Therapy, Alternative Schools,  
School-Based Psychotherapy, Single-Case Research

Martha Cord Hinchey \_\_\_\_\_  
Student's Signature

07-21-15 \_\_\_\_\_  
Date

THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT)  
WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT

By

Martha Cord Hinchey

Dr. H. Thompson Prout

Director of Dissertation

Dr. Kenneth Tyler

Director of Graduate Studies

07-21-15

Date

*For my parents – you are my forever cheerleaders.*

*P<sup>3</sup>M<sup>2</sup>F*

## ACKNOWLEDGEMENTS

First, I would like to express immense gratitude to my parents for their incredible support, words of encouragement, use of laughter, and motivational voicemails. Your presence and guidance throughout my educational pursuits (or as you both dubbed “never-ending hoops and hurdles”) is remarkable, and I am a very lucky woman to be able to call you my parents.

I would also like to especially thank the members of my dissertation committee. Words cannot express how appreciative I am for your insight, challenges, and mentorship throughout my graduate school career. Thank you, Dr. Tom Prout, for guiding me in both my academic and professional endeavors. Your practicality, use of humor, and positivity undoubtedly contributed to my success. Thank you, Dr. Alicia Fedewa, for your affirmations and contagious energy. Your enthusiasm and love for our field has impacted me greatly, and I hope to bring the same level of energy to the next chapter of my life. Thank you, Dr. Jeff Reese, for helping me to realize my potential as a practitioner and researcher. The knowledge and experiences I gained in the Counseling Psychology program with you have influenced my present research interests and clinical behavior, and for that, I am forever grateful. Thank you, Dr. Jamie Studts, for taking me on as a graduate research assistant and for developing my “researcher skills”. You make research fun. I have had so many memorable (i.e., hilarious) assistantship experiences with you, and will laugh about them for years to come.

Lastly, I would like to thank Dr. Rachel Hammond, and Dr. Jennifer Hoffman. Thank you, Dr. Hammond, for always encouraging me, being my biggest fan, and counseling me throughout this doctoral journey. You have been an integral part of my success. I truly cannot express my gratitude enough to you for your support. Thank you,



Dr. Hoffman, for being my “other half” in graduate school. I am so lucky to have you as both a close friend and colleague. I honestly would not have been able to get through these past five years without you and our endless laughter.

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## **Chapter One: Introduction and Review of Related Literature**

The examination of mental health interventions within the school domain is substantiated in the youth psychotherapy literature (Borntrager & Lyon, 2015; Connors, Arora, Curtis, & Stephan, 2015; Ray, Armstrong, Balkin, & Jayne, 2014; Zirkelback & Reese, 2010). Research indicates the potential interconnectedness between academic and behavioral functioning and suggests that schools may be in a unique position to offer preventative and immediate interventions to address their relatedness (Borntrager & Lyon, 2015; Prout & Prout, 1998; Ray et al., 2014). Further, “as all children are required to attend school, and are consequently provided adequate transportation, the school building becomes an ideal environment for the assessment and provision of therapeutic services, often eliminating the transportation, insurance, and social stigma barriers” (Zirkelback & Reese, 2010, p. 1095). The provision of psychotherapeutic services within an academic environment may in turn eliminate external barriers (e.g., transportation, insurance, social stigma) that potentially hinder youth from obtaining these services. A review of the literature in this area indicates an increase in support for the consideration of mental health needs within school settings due to the potential benefit of mental health services on students’ overall functioning within this environment (Borntrager & Lyon, 2015).

As identified by Ray, Armstrong, Balkin, and Jayne (2014), “given that children’s mental health is a growing crisis in the United States, the need for intervention is apparent” (p. 115). Further, school-based mental health interventions that utilize evidence-based assessments (EBA) as a part of their psychotherapeutic approach is substantiated in the literature (Connors et al., 2015). These interventions may “include

the ongoing monitoring of a youth's progress, which can assist in determining whether modifications to treatment are needed and treatment can end" (Connors et al., 2015, p. 60). Of note, school psychologists, who are capable mental health clinicians, implement counseling services on an infrequent basis compared to their other daily obligations (Connors et al., 2015; Perfect & Morris, 2011; Suldo, Friedrich, & Michalowski, 2010). Though governing bodies, such as the National Association for School Psychologists (NASP) promote evidence-based mental health in schools, perceived systems-level and personal barriers (e.g., insufficient training and preparation, lack of support from department, district administration, and school personnel, feelings of role strain) appear to hinder school psychologists' more frequent incorporation of these interventions with school-aged youth (Connors et al., 2015; Perfect & Morris, 2011; Suldo et al., 2010).

The increased utilization of preventive services and frameworks, such as Response to Intervention (RTI) and a heightened focus on accountability within education and special education, has subsequently influenced the desire for an increase in evidence-based interventions in schools. Progress monitoring, which comprises RTI services, allows school clinicians to track the impact of specific interventions on academic and behavioral outcomes. A review of the school-related literature indicates more research on EBAs for academic deficits than on EBAs for mental health concerns. Data-driven psychotherapy in schools may evaluate the therapy process through various means (e.g., standardized outcome measures, progress-monitoring, self-reported analysis of behavior), with the primary goal of assessing and promoting students' success within the academic setting (Borntrager & Lyon, 2015; Kratochwill, 2007).



Research on school-based mental health indicates the use of a number of psychotherapies within this environment. One such psychotherapy is solution-focused brief therapy (SFBT), which is marked by its brief, client-centered, collaborative, and goal-directed nature. In addition, SFBT incorporates progress-monitoring strategies (e.g., scaling questions, outcome measures) to assist in measuring self-reported therapeutic progress. Through present- and future-focused inquiry, practitioners assist clients in identifying personal strengths and resources and create opportunities for clients to apply solutions to their problems. SFBT has received recognition by the Substance-Abuse Mental Health Services Administration's National Registry of Evidence-Based Program and Practices (SAMHSA-NREPP) as an evidence-based group therapy practice. Though the literature indicates some support for the implementation of SFBT within school environments, more rigorous research on the use of school-based SFBT with at-risk populations is warranted.

## **Review of Related Literature**

### **Youth Psychotherapy Research**

Research on psychotherapy response and outcomes (e.g., academic performance, emotional and behavioral functioning) in children and adolescents yields moderate effects for treatment versus control conditions (Ray et al., 2014; Reynolds, Wilson, Austin, & Hooper, 2012; Schmidt & Schimmelmann, 2015). This may indicate that youth engaged in mental health services experience better outcomes compared to those who do not receive treatment. A review of the related literature also indicates that these better outcomes are demonstrated with a variety of treatment modalities utilized, primary area(s) of concern, and measurement tools employed (Prout & Prout, 1998; Zirkelback &

Reese, 2010). The effectiveness of psychotherapy with children and adolescents in different practice settings (e.g., outpatient, inpatient, schools) is also evidenced in the literature (Erford et al., 2011).

**Outcomes for children and adolescents.** Prout and DeMartino (1986) presented one of the first meta-analyses involving the examination of the effectiveness of school-based therapeutic interventions. Results from their study indicated an overall effect size (ES) of  $d = 0.58$  for school interventions; further, group interventions appeared more effective than individual interventions ( $d = 0.93$  versus  $d = 0.39$ , respectively). Results from Prout and DeMartino (1986) also indicated that behavioral interventions were somewhat more effective than non-behavioral interventions ( $d = 0.65$  versus  $d = 0.40$ , respectively), and that there were slight differences between elementary school intervention students ( $d = 0.52$ ) and middle school intervention students ( $d = 0.65$ ). (Prout & DeMartino, 1986)

Over a decade later, Prout and Prout (1998) conducted an updated meta-analysis and analyzed published studies in this area within the previous 10-year period. Researchers identified 17 studies and compared effect sizes (ESs) of mean baseline-posttest changes between experimental and control groups. Results indicated that, “students treated in schools or for school-related problems improved almost one standard deviation when compared to students who did not receive treatment” (Prout & Prout, 1998, p. 129). Further, cognitive-behavioral strategies evidenced the strongest effects ( $d = 1.45$ ), and self-report measures appeared to suggest the most responsiveness to treatment ( $d = 1.18$ ). Results also indicated that students in elementary school ( $d = 1.31$ ) and depressed youth ( $d = 1.96$ ) were most responsive to interventions when compared to

older students and those with other emotional and/or behavioral concerns. In addition to strengths denoted in their research, Prout and Prout (1998) also identified several considerations of their findings. Researchers highlighted that “self-reported ‘affective’ or ‘internal’ changes [were] the most likely changes to be found as the result of treatment in the schools” (Prout & Prout, 1998, p. 133). This is in contrast to externalizing behavioral changes. In regard to responsiveness to treatment and age-ranges, results indicated that youth in elementary school were most responsive to treatment versus those in middle or high school. Prout and Prout (1998) also denoted that their findings primarily relate to group therapy designs versus individual settings. Results indicated in this study may assist future research on psychotherapy with children and adolescents in the identification of potential moderator variables (e.g., type of therapy, assessment tools, age, presenting concern) that may impact youth treatment outcomes. Overall, findings presented in Prout and Prout (1998) appear to provide support for school-based mental health services, as evidenced in the improved outcomes for youth exposed to therapeutic interventions, versus those in control conditions.

In Erford et al. (2011), researchers conducted a meta-analysis of clinical trials that examined the use of psychotherapy with children and adolescents experiencing depressive symptoms. The methodologies employed in the reviewed studies were single-subject pretest-posttest designs and randomized samples (i.e., included a comparison of treatment groups versus to wait-list groups and various types of treatment as usual [TAU] control groups). Erford et al. (2011) sought to determine the effectiveness of psychotherapy with youth involved in treatment groups when compared to control groups, the long-term impact of therapy on outcomes, and the successfulness of

psychotherapy within various practice domains (i.e., schools, clinics, and outpatient conditions). Results yielded a small weighted ES ( $d^+ = 0.36$ ) for single-group conditions at termination, indicating that the average participant at termination scored at the 64<sup>th</sup> percentile of the pretest score distribution ( $d^+ = 0.36$ ). A medium weighted ES ( $d^+ = 0.46$ ) was calculated at follow-up for single-group conditions. Results yielded a medium weighted ES when comparing treatment groups to wait-list controls at termination ( $d^+ = 0.55$ ); this indicates that the average treatment group participant was less depressed than were 71% of the wait-list control participants at termination. Results indicated a small weighted ES ( $d^+ = 0.29$ ) when comparing treatment versus wait-list comparison groups at follow-up. Results indicated a small weighted ES for treatment groups compared to treatment as usual (TAU) controls at termination ( $d^+ = 0.29$ ), which suggests that the average participant in the treatment condition performed at the 62<sup>nd</sup> percentile of the TAU comparison group distribution; a very small weighted ES was reported at follow-up ( $d^+ = 0.16$ ). Results indicated no significant effects of treatment at termination when comparing treatment versus placebo group conditions ( $d^+ = 0.01$ ); however, only two studies were included in this analysis. In regard to psychotherapy effects within different practice settings, results at posttest and follow-up for wait-list and TAU conditions indicated no significant differences between school-based and outpatient-based results. In sum, findings evidenced in Erford et al. (2011) appear to provide support for the utility of psychotherapy with depressed youth, the potential lasting impact of therapy on symptomatology maintenance and/or reduction, and the benefit of psychotherapy across practice settings.

In Reynolds et al. (2012), researchers conducted a meta-analysis of randomized controlled trials (RCTs) that examined the use of different psychotherapies with children and adolescents experiencing anxiety. Reynolds et al. (2012) compared the ESs of youth exposed to cognitive-behavioral therapy (CBT) interventions versus control conditions, analyzed the use of CBT with various anxiety-related disorders (i.e., generalized, disorder-specific), and assessed the impact of potential moderator variables (i.e., age, treatment delivery) on therapy outcomes. Overall, results indicated a moderate to large ES for those involved in anxiety-focused treatment versus youth in control groups. In regard to the use of CBT with different anxiety-related disorders, results suggested more substantial outcomes for disorder-specific CBT treatments ( $d = 0.77$ ) versus CBT treatments with generalized anxiety concerns ( $d = 0.53$ ); however, CBT was observed to be moderately effective in alleviating symptoms of generalized anxiety. Findings in Reynolds et al. (2012) also suggested that CBT may be beneficial with both children ( $d = 0.63$ ) and adolescents ( $d = 1.38$ ). Adolescents, however, appeared to experience more significant treatment outcomes versus younger youth. In regard to treatment delivery, results suggested that individual treatment settings (i.e., for both CBT-guided psychotherapy and general psychotherapy for anxiety) evidenced better outcomes ( $d = 0.85$  and  $d = 0.75$ , respectively) versus both CBT-guided group psychotherapy and general group treatments for anxiety ( $d = 0.58$  and  $d = 0.57$ , respectively). Overall, findings from this study suggest that youth may experience better outcomes when exposed to mental health interventions versus TAU and that CBT may be an effective treatment for anxiety-related issues. Further, findings indicate that age as a moderator variable is unclear due to the benefit exhibited in both child and adolescent outcomes;

however, it appears that treatment delivery may impact outcomes, as evidenced in the more substantial results for those provided with individual treatments.

Psychotherapy efficacy for externalizing problem behaviors in youth is also reflected in the literature. Disruptive behavior disorders, which are marked by these externalizing emotional and behavioral issues, include conduct disorder (CD), oppositional defiant disorder (ODD), and attention-deficit/hyperactivity disorder (AD/HD). Compared to other mental health concerns (e.g., internalizing concerns), disruptive behavior disorders are easier to recognize due to the overt manifestation of symptomatology exhibited in youth. A review of the literature in this area indicates that psychotherapy with parental inclusion may yield positive outcomes for children and adolescents experiencing externalizing behaviors (e.g., Hood & Eyberg, 2003; Thomas & Zimmer-Gembeck, 2007). Further, research on youth psychotherapy suggests that therapies with a behavioral framework may yield beneficial treatment outcomes for youth experiencing overt behavioral problems (Bond et al., 2013; Franklin et al., 2008; Hood & Eyberg, 2003). Overall, due to the prevalence and chronicity of these disorders, more research is needed on specific therapeutic interventions that are successful with these populations (Hood & Eyberg, 2003).

Based on a review of the child psychotherapy literature, it appears that youth involved in therapeutic interventions experience greater outcomes than those not exposed to these services (Ray et al., 2014; Reynolds et al., 2012; Schmidt & Schimmelmann, 2015). Research also suggests that this potential benefit is reflected across practice domains (e.g., schools, outpatient clinics, inpatient facilities) and with a range of presenting concerns (e.g., depression, anxiety, externalizing issues), which may provide

support for the inclusion of psychotherapy services within the school domain. More research on the effectiveness of psychotherapy services with children and adolescents, and on potential variables that may impact treatment outcomes, is warranted.

### **Influences on Therapy Outcomes**

Schmidt and Schimmelmann (2015) suggest that, “clinical decision-making and treatment development is hampered by our lack of understanding of the mechanisms by which change occurs in psychotherapy” (p. 252). A review of the related literature indicates that researchers have identified certain moderator variable that may impact a client’s response to and outcomes of psychotherapy. These variables may include both therapist characteristics (e.g., gender, age, cultural background, training, orientation, personality type) and client-related factors (e.g., gender, age, cultural background, degree of disturbance, unique strengths, personality type). The literature in this area also indicates that the perceived relationship between the client and therapist, or therapeutic alliance, may be considered a potential predictor of treatment outcomes (Martin et al., 2000). Of note, research also suggests that, “predicting benefit from psychotherapy...is complicated by the fact that individuals (and groups of individuals) do not all have the same likelihood or probability of receiving benefits” (Lindhiem, Kolko, & Cheng, 2012, p. 382). Thus, though the literature supports that there are variables that may impact psychotherapy response and outcomes, it is challenging to identify a single predictor variable or group of variables that account for the variability in therapy responses and outcomes (Lindhiem et al., 2012).

**Therapeutic alliance.** Alliance may refer to the quality of the relationship between the client and therapist and potential bond that may emerge between these

individuals over the course of treatment (Kazdin & Durbin, 2012). As noted in Bordin (1979), “the effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance” (p. 253). Thus, clients’ perceptions of the therapeutic relationship may subsequently have a potential impact on the direction of therapy. A review of the related literature yields support for the consideration of alliance as a moderator variable and indicates a moderate effect on treatment outcomes (e.g., Chiu, McLeod, Har, & Wood, 2009; Kazdin & Durbin, 2012; Zirkelback & Reese, 2010).

**Other variables.** In regard to client characteristics, age, as a potential moderator variable, has been examined; however, research indicates variable findings. Some researchers determined that children experienced greater success in therapy when compared to adolescents (e.g., Prout & Prout, 1998; Weisz, Weiss, Alicke, & Klotz, 1987; Zirkelback & Reese, 2010). In contrast, others indicated that adolescents experienced the better treatment outcomes (e.g., Bennett & Gibbons, 2000; Reynolds et al., 2012; Weisz, Weiss, Han, Granger, & Morton, 1995). Thus, as evidenced, more research on the impact of age on treatment outcomes is warranted.

As discussed by Kazdin and Durbin (2012), for youth experiencing externalizing problem behaviors, “several factors at pretreatment are known to influence therapeutic change of the child, including socioeconomic disadvantage, parent psychopathology and stress, and severity and scope of child dysfunction” (p. 203). These factors may be considered when working with children and/or adolescents presenting with overt emotional and behavioral behaviors.

Overall, research indicates some evidence in support of the relationship between the quality of the therapeutic alliance and treatment outcomes. Though other potential



factors (e.g., age, level of functioning, environmental challenges) are identified in the literature, more research is required in order to better assess potential client and therapist characteristics that may influence the effectiveness of treatments. Lastly, in order to further promote clients' successfulness in psychotherapy, researchers need to "identify youth 'at risk' for not forming an alliance and engaging in the processes critical to therapy" (Kazdin & Durbin, 2012, p. 210). This identification may allow clinicians to then determine the most "ideal fit" for youth seeking therapeutic services.

### **School Psychologists and Practice-Related Behaviors**

There are a number of mental health providers that offer therapeutic services to youth (e.g., psychologists, social workers, school psychologists) in a variety of settings (e.g., private practices, outpatient clinics, inpatient facilities, schools). School psychologists, who may engage with children and adolescents at all developmental periods, are in a unique position to offer school-based mental health services due to their accessibility to a range of youth populations. Research indicates that the role(s) of school psychologists has slowly evolved over time and that there has been a gradual expansion in their scope of practice to include more responsibilities within schools. At the same time, it appears that school psychologists may face challenges with this expansion. In Bramlett, Murphy, Johnson, Wallingsford, and Hall (2002), researchers sought to determine the types of practice-related activities conducted by these professionals, as well as the percentage of time delineated to each area. Results indicated that the majority of their time was dedicated to assessment (46%). Following this area, consultation (16%), the provision of interventions (13%), counseling (8%), and conferencing (7%), comprised the rest of their daily practices. Other roles, though infrequent, included supervision

(3%), participation in professional inservices (2%), research (1%), parent training (1%), and other-related activities (3%). Findings suggest that school psychologists more often engage in assessment than any other practice, with counseling as an infrequent practice as compared to other areas. Research indicates comparable results, as “school psychologists report a high level of job satisfaction, but there continues to be a discrepancy between desired and actual roles with a reported over-emphasis on special education eligibility assessments” (Ysseldyke et al., 2006, p. 10).

One area that reflects this discrepancy is in the implementation of school-based mental health services. Research indicates that though school psychologists may be motivated to provide counseling services (Agresta, 2004), potential barriers may impact their implementation. In Suldo et al. (2010), researchers examined the extent of these barriers on practice behaviors and identified commonalities between school psychologists’ self-reported concerns. Results external barriers that pertained to systems-level issues (e.g., schools as sites for service delivery, insufficient site-based training, and lack of support from department, district administration, and school personnel), as well as, other individualized barriers related to insufficient professional preparation and feelings of role strain (Suldo et al., 2010).

Of note, it appears that there is a need for school psychologists to expand their roles to include the facilitation of more preventative and immediate services within this environment due to a variety of factors. The potential link between academic outcomes and behavioral functioning is reflected in the literature, as “children’s mental health needs have become a critical public health issue that directly affects teaching and learning” (Ysseldyke et al., 2006, p. 9). School psychologists as providers of mental

health services is supported by the National Association for School Psychologists (NASP), and the provision of evidence-based emotional and behavioral interventions within the school environment is an expected domain of competence for graduate students in training and for those in practice. As indicated in NASP's *Blueprint III* (2006), "there has never been a greater need for school psychologists to take leadership in ensuring quality mental health services for children" (Ysseldyke et al., 2006, p. 9).

In sum, there is evidence in support of a shift from school psychologists' traditional roles to more expansive practice-related behaviors (e.g., the provision of mental health interventions). Schools may be an ideal setting for the inclusion of psychotherapeutic interventions, and school psychologists are capable mental health providers. Though there are apparent barriers to the implementation of these services by school psychologists, research indicates a need for the provision of mental health interventions due to the prevalence and chronicity of emotional and behavioral concerns within the academic environment (Borntreger & Lyon, 2015; Ray et al., 2014).

### **Overview of SFBT**

A particular therapeutic orientation that has been utilized with youth in a school setting is SFBT. From a broad perspective, SFBT may be described as a celebration of the client through acknowledgement, positivity, and collaboration. It includes a solution-building dialogue, a focus on strengths and small successes, and the use of "miracle" and scaling questions. Further, SFBT is guided by progress monitoring tools to assess behavioral change over the course of treatment. It is also driven by the idea that the client is viewed as the "expert" and ultimately directs the therapeutic process.

A primary aim of SFBT is to provide a collaborative and co-constructed therapy

experience. Co-construction is viewed as a primary force behind behavioral change, and is defined as “a collaborative process in communication where speaker and listener collaborate to produce information together, and this jointly produced information in turn acts to shift meanings and social interactions” (Bavelas et al., 2013, p. 5). The conversational principles within SFBT are consistently infused within the therapy dialogue, irrespective of the client’s presenting concerns, and highlight present and future client-directed goals (Bavelas et al., 2013). Another aim of SFBT is to provide feedback to the client using data collected from the client’s remarks during therapy and overall interactions with the therapist. According to Bavelas et al. (2013), the SFBT clinician:

“listens for and selects out the words and phrases from the client’s language that are indications (initially, often only small hints) of some aspect of a solution, such as articulating what is important to the client, what he or she might want, related successes (e.g., exceptions), or client skills and resources. Once having made the selection, the therapist then composes a next question or other response (e.g., paraphrase or summary) that connects to the language used by the client and invites the client to build toward a clearer and more detailed version of some aspect of the solution.” (p. 5)

Listening, selecting, and building, are major components of SFBT. Through these techniques, the therapist and client co-construct more meaningful and measureable solutions to the client’s identified problem areas.

SFBT is a well-suited mental health intervention within a school environment for a myriad of reasons. As stated in its name, SFBT is, at its very core, a brief form of therapy. This brief nature is evidenced in both the number of sessions and duration (i.e.,

minutes) of individual or group sessions in SFBT. For schools, which tend to be limited by time-constraints, the design and goals of SFBT fit in well within this more restricted environment. As noted in Kim and Franklin (2009), SFBT “tries to engage and focus on quick change with children, families, and teachers” (p. 465). Goals in SFBT are explicit and observable, which aligns with schools’ focus on assessment and outcome measurement. Further, because clients are viewed as the experts, the identified goals for therapy are student-directed and thus, are more personally meaningful. Instead of dwelling on problem behaviors, the SFBT clinician examines what is working with students, utilizes their strengths to overcome these behaviors, and closely monitors behavioral change.

### **Comparison of SFBT to Other Psychotherapies**

SFBT embodies both similarities and contrasting assumptions to several psychotherapies and theories in existence today. The work of Milton Erickson, M.D., American psychiatrist and researcher, was a major influence on the theoretical underpinnings of SFBT. As noted in Murphy (2008), Erickson endorsed the belief that clients are the best teachers, that therapeutic solutions can be discovered quickly and independently of detailed information about the problem, and that clients already possess the strengths and resources required for change. These assumptions mirror those of SFBT. Additionally, Erickson’s “crystal ball technique,” wherein client’s imagine and describe a problem-free future, is very similar to the “miracle question” in SFBT (Murphy, 2008). Another theoretical framework linked to SFBT is social constructivism. According to Bannink (2007), SFBT was originally developed from social constructivism, which is marked by the belief “the individual’s idea about what is real-

including the idea of the nature of his problems, competencies, and possible solutions- is being construed in daily life communication with others” (p. 89). Furthermore, within this perspective, “consideration is given to how the therapist can contribute to the creation of a new reality for the client” with the “capacity of the client for change...connected to his ability to begin seeing things differently” (Bannink, 2007, p. 89). This emphasis on co-construction is a primary foundation in SFBT.

In addition to the work of Erickson and to social-constructivism, SFBT is also linked to other theoretical frameworks. These include cognitive-behavioral therapy (CBT), motivational-interviewing (MI), and family systems therapy. As indicated in the following sections, these three psychotherapies embody both complementary and contrasting perspectives to those evidenced in SFBT.

**Cognitive-behavioral therapy (CBT).** CBT focuses on the triangular relationship between one’s thoughts, emotions, and behaviors. In CBT, clients must first identify and then alter their maladaptive thinking patterns; this may in turn impact their emotional and behavioral responses. Following exploration of the problem, clients are required to complete “homework assignments” wherein they practice the CBT-related strategies discussed during therapy. Central tenets of CBT include that, “cognitive activity affects behavior. Cognitive activity may be monitored and altered. Desired behavior change may be affected through cognitive change” (Dobson & Dozois, 2001, p. 4). Though client action is a major aspect of CBT, the clinician is also actively involved in the therapeutic process and provides instruction to assist clients in adaptively managing the triangular relationship between thoughts, feelings, and behaviors.

SFBT is similar to CBT in that both emphasize clients' strengths, focus on goals and outcomes, and encompass progress monitoring through homework assignments. In contrast to the more problem-focused nature of CBT, SFBT lacks an exploration of the origins of the identified problem. CBT also appears to be more therapist-directed, which is evidenced in the instructional role that is reflected in this orientation. In contrast, the client is identified as the expert in SFBT and guides the therapeutic process.

**Motivational-interviewing (MI).** MI is defined as a therapeutic approach that focuses on resistance to change, on ambivalence about change, and on increasing intrinsic motivation to help guide behavioral change (Arkowitz & Miller, 2008). According to Arkowitz and Miller (2008), MI “works from the assumption that many clients who seek therapy are ambivalent about change and that motivation may ebb and flow during the course of therapy” (p. 2). In MI, the clinician is guided by the principles of expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy (Arkowitz & Miller, 2008).

Both MI and SFBT are client-centered, collaborative, and structurally flexible. In MI, a primary goal is “to increase intrinsic motivation to change- that which arises from personal goals and values rather than from such external sources as others' attempts to persuade, cajole, or coerce the person to change” (Arkowitz & Miller, p. 2). This goal is well aligned with the major principles in SFBT. However, though the perspectives within MI and SFBT are fairly comparable, there appears to be a more clearly defined model of change and more directive methods of client confrontation in MI when compared to SFBT.

**Family systems therapy.** Family systems therapy is guided by a belief of the client as a part of several larger, interconnected, and collaborative systems (e.g., family, school, and community). Within this type of therapy, “the focus of treatment is not on locating the pathology within the individual but on mobilizing resources and targeting areas of resiliency and strength in the family” (Atwood, 2001, p. 1). The individual is viewed as a subsystem within the family, wherein members are equally effective in contributing to and/or altering familial dynamics. Further, family systems therapy is rooted in the idea that, “causality is circular and the interrelationships among the members are such that as one member changes, all members must somehow change and adapt in relation to that member” (Atwood, 2001, p. 2).

Both family systems therapy and SFBT acknowledge the importance of personal strengths in solution-building; these orientations also lack a deficit- or problem-focus. Family systems therapy and SFBT are similarly aimed at assisting clients with recognizing and then utilizing available resources. In contrast to family systems therapy, SFBT does not include a primary focus on the examination of individuals as part of a larger unit. An additional difference between these therapies is that, unlike family systems therapy, SFBT focuses on strengths and resources that are more individualized and personally relevant; in family systems therapy, there appears to be a recognition of external strengths and resources, like those in family members.

In sum, SFBT has been influenced by several theoretical frameworks. These include Erickson’s work, social-constructivism, CBT, MI, and family systems therapy. However, though many components of SFBT are similarly reflected in the identified orientations, there are inherent differences between them as well.



## **SFBT Research**

Research on the implementation of school-based SFBT is evidenced in the literature. However, there appears to be a discrepancy in the number of studies conducted in “regular” school settings versus those in “alternative” schools (i.e., limited research is available on SFBT and youth outcomes in “alternative” schools).

**Definitions of terminology.** According to the United States Department of Education (2010), a “regular” school setting is defined as: “a public elementary/secondary school providing instruction and education services that does not focus primarily on special education, vocational/technical education, or alternative education, or on any of the particular themes associated with magnet/special program emphasis schools” (p. 61). Though the definition of an “alternative” school environment is variable, the United States Department of Education defined this type of school as:

a public elementary/secondary school that (1) addresses needs of students that typically cannot be met in a regular school, (2) provides nontraditional education, (3) serves as an adjunct to a regular school, or (4) falls outside the categories of regular, special education, or vocational education. (U.S. Department of Education, 2010, p. 61)

According to Johnson and Taliaferro (2012), alternative schools “serve a vulnerable population of youth disproportionately impacted by social and individual-level risk factors that contribute to health disparities” (p. 79). Furthermore, those students within these environments are at a much higher risk for failing out of school than those in regular settings and “more often experience social and emotional problems, as well as chaotic environments characterized by frequent moves, abuse, or parental substance use”

(Johnson & Taliaferro, 2012, p. 79). Students are enrolled in alternative schools for a plethora of reasons, ranging from severe behavioral and/or emotional problems, truancy, and/or substance use, among others (Becker, 2010).

**Regular school settings.** Newsome (2005) sought to examine the impact of SFBT on behavioral outcomes (i.e., social skills, classroom behavior, and homework completion) in at-risk youth. Participants included both male (72%) and female (27%) middle school students. According to Newsome (2005), participants were “at risk of academic problems based on below average academic performance and/or chronic and/or low attendance from the previous academic year and who [were] not receiving or currently under the provisions of an individual education plan (IEP)” (p. 84).

Three instruments were utilized in this study and included the Homework Problem Checklist (HPC; Anesko, Schollock, Ramirez, & Levine, 1987), Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998), and Social Skills Rating System (SSRS; Gresham & Elliott, 1990). The SSRS was administered at weeks one and eight; it was also completed at 6-month follow-up. Parents completed the HPC at the beginning and end of treatment. Teachers were administered the BERS at the beginning and end of treatment.

Results were analyzed using univariate, bivariate, and multivariate statistical methods to assess the utility of SFBT. Overall, participants scored significantly better on the BERS ( $M=64.88$  [pretest];  $M = 75.23$  [posttest]) and the SSRS ( $M = 42.34$  [time 1];  $M = 51.81$  [time 2];  $M = 49.73$  [time 3]) after the SFBT group sessions and at 6-week follow-up when compared to results at pretest. This reflects that students experienced an increase in pro-social behavior and a decrease in problem behaviors in the classroom. As

discussed by Newsome (2005), “changes on the SSRS and BERS instruments are of particular interest because they suggest a potential link between the participants’ recognition of dealing appropriately with teachers and peers in the classroom and the interpersonal strengths developed during SFBT treatment” (p. 88). In addition to these results, parents perceived fewer issues related to homework completion (i.e., more on-task behaviors) following students’ participation in treatment ( $M = 31.57$  [pretest];  $M = 27.73$  [posttest]). Results also indicated positive outcomes in social and behavioral functioning, as well as in behaviors associated with homework completion. This study provides potential support for the utilization of SFBT with at-risk middle school students, specifically, when focusing on increasing self-awareness and adaptive coping skills within this population.

Franklin, Moore, and Hopson (2008) assessed the implementation of SFBT with middle school children who exhibited internalizing and externalizing problem behaviors in the classroom. Principals and teachers identified and recruited students from two junior high schools. Students were selected in each of the schools if they had received more than one behavioral referral from a classroom teacher. According to Franklin et al. (2008), “the behavioral referral [was] an incident report that require[d] disciplinary action and referral for pupil services. Common reasons for behavioral referrals include[d] inattentiveness, tardiness, school phobia, difficulty completing tasks, and social problems that affect[ed] school performance” (p. 17).

Researchers utilized a quasi-experimental design wherein the control and intervention groups were located at two different schools to eliminate potential contamination via interactions between students in each group. The experimental group

participated in 5-7 sessions of SFBT, which lasted around 30-45 minutes. Each session contained the SFBT techniques of the "miracle question", exceptions to the problem, scaling questions, and coping and motivational questions. Sessions also included a break and a formulated task. A 4-hour teacher in-service training, 3-4 teacher-practitioner consultation meetings, and 1-2 formal meetings with the teacher, practitioner, and student were also included in the study. The Child Behavior Checklist-Youth Self-Report (CBCL-YSR; Achenbach, 1991) and Child Behavior Checklist-Teacher Report Form (CBCL-TRF; Achenbach & Edelbrock, 1983, 1986) were used at pretest, posttest, and 1-month follow-up to assess the effectiveness of SFBT. Researchers specifically examined the internalizing and externalizing scores on the YSR and TRF to evaluate treatment outcomes.

Results from this study indicated that children who received the SFBT intervention scored significantly lower on the two measures than those in the comparison group. Scores in the experimental group moved to below the clinical cutoff ( $T \geq 60$ ) from pretest to posttest and maintained this score at follow-up for teachers' report of internalizing symptoms ( $M = 66.80$  [pretest];  $M = 57.00$  [posttest];  $M = 57.30$  [follow-up]), teacher's report of externalizing symptoms ( $M = 67.60$  [pretest];  $M = 58.20$  [posttest];  $M = 58.40$  [follow-up]), and students' report of externalizing symptoms ( $M = 69.90$  [pretest];  $M = 59.30$  [posttest];  $M = 57.50$  [follow-up]). Scores on the children's report of internalizing symptoms were not clinically significant due to improvement in both groups. Scores from teachers' reports and students' self-reports in the comparison group indicated clinically significant scores from pretest to follow-up, except in the area of internalizing symptoms at follow-up ( $M = 58.70$ ). The following ES

estimates were calculated:  $d = 0.61$  (CBCL-TRF externalizing);  $d = 1.40$  (CBCL-TRF internalizing);  $d = 0.86$  (CBCL-YSR externalizing); and  $d = 0.08$  (CBCL-YSR internalizing). Scores from these ES estimates indicated significant change between groups overtime for teacher-rated externalizing symptoms, teacher-rated internalizing symptoms, and youth self-reported externalizing symptoms. Overall, results of this study provide potential support for the use of SFBT as a short-term intervention within an academic environment.

In Kim and Franklin (2009), researchers conducted a meta-analysis on outcome studies that included school-based SFBT. Primary studies with experimental designs were included. ES estimates were compared between the studies, and if ESs were not calculated and provided in the original research article, Kim and Franklin (2009) computed the calculations. Researchers identified three types of problem areas across these studies. These included externalizing issues, internalizing concerns, and family and relationship problems. Overall, Kim and Franklin (2009) included seven studies in their review (see Table 1). Of these studies, one study employed an experimental design, five studies utilized quasi-experimental designs, and one study used a single-case design.

Table 1

*Summary of SFBT Studies*

Study	Design	Sample Size	Participants	Concerns	Reported Effect Sizes (ES)
<b>Corcoran (2006)</b>	Quasi-experimental	86	Elementary, Middle, and High School students	Aggression; Defiance; Work completion	<b>0.08</b> (Parent report-emotional/ behavioral functioning); <b>0.48</b> (Youth report-emotional/ behavioral functioning)
<b>Franklin, Moore, &amp; Hopson (2008)</b>	Quasi-experimental	59	Middle School students	Attention; Social problems; School-related concerns	<b>1.40</b> (Teacher-internalizing); <b>0.61</b> (Teacher-externalizing); <b>0.08</b> (Youth-internalizing); <b>0.86</b> (Youth-externalizing)
<b>Franklin, Streeter, Kim, &amp; Tripodi (2007)</b>	Quasi-experimental	85	At-risk High School students	School dropout	<b>0.47</b> (Credits earned); <b>1.63</b> (Attendance)
<b>Franklin, Bieber, Moore, Clemons, &amp; Scamardo (2001)</b>	Single-case	7	Middle School students	Learning and behavioral challenges	--
<b>Froeschle, Smith, &amp; Ricard (2007)</b>	Experimental	65	Middle School students (8 <sup>th</sup> grade females)	Drug use; Academics; Internalizing behaviors	<b>0.65</b> and <b>0.76</b> (Substance use; Attitudes); <b>1.76</b> (Knowledge); <b>0.17</b> (Self-esteem); <b>0.63</b> and <b>1.16</b> (Behavioral competence)
<b>Newsome (2004)</b>	Quasi-experimental	52	Middle School students	Truancy; Academic performance	<b>0.43</b> (Grades)
<b>Springer, Lynch, &amp; Rubin (2000)</b>	Quasi-experimental	10	Elementary School students	Emotional/behavioral concerns; Trauma	<b>0.57</b> (Self-esteem)

Kim and Franklin (2009) reported mixed results regarding the efficacy of school-based SFBT. Results indicated small, but positive, treatment effects in support of SFBT approaches with the identified youth. For those studies that examined the use of SFBT with externalizing behaviors, results indicated a potential benefit for these youth. As noted in Kim and Franklin (2009), “the positive findings for behavioral outcomes may have considerable clinical significance for school-based practitioners because of the size of the effect sizes achieved coupled with the fact that most of the studies involved salient

issues for school practitioners (e.g., conduct problems, hyperactivity, substance use)” (p. 468). Further, SFBT “can be effective in helping to create change in the target problem quickly, as well as helping to identify specific goals collaborated on by both the client and the therapist” (Kim & Franklin, 2009, p. 468). In Franklin, Kim, and Brigman (2012) strengths of this meta-analysis were included. These researchers identified that, “studies were conducted by more than one investigator, us[ed] treatment manuals or protocols, employ[ed] standardized measures and a fidelity evaluation” (Franklin et al., 2012, p. 236). In addition, researchers reportedly conducted these studies within real-world environments, further supporting the usability of SFBT within a more naturalistic setting (e.g., schools).

Kim and Franklin (2009) also presented potential limitations of these SFBT studies. Results indicated that in a study on the relationship between SFBT and attendance, there was no difference at posttest between students in the SFBT group and those in the comparison group. Also, in another study reviewed, there was no difference in self-esteem ratings between groups at posttest. Franklin et al. (2012) identified a weakness of the included studies in that “samples tended to be small, which limits statistical power to detect treatment effects and generalizability” (p. 236). In addition, most of the studies utilized a quasi-experimental design; though it may be challenging to incorporate randomization within a school environment, it should be considered in future research conducted in this area.

**Alternative school environments.** Research on the effectiveness of SFBT within alternative school environments is considerably more limited than within regular school settings. To reiterate, an alternative school setting is typically comprised of at-risk youth

with emotional and/or behavioral challenges that have subsequently impacted their successfulness in regular school settings. In a study conducted by Franklin, Streeter, Kim, and Tripodi (2007), researchers sought to evaluate the effectiveness of a solution-focused alternative high school in the prevention of student dropout. According to Franklin et al. (2007), in order to be considered a solution-focused alternative school (SFAS), the following characteristics must be evidenced: (1) faculty emphasis on building students' strengths, (2) attention given to individual relationships and progress of the students, (3) emphasis on the students' choices and personal responsibility, (4) overall commitment to achievement and hard work, (5) trust in students' evaluations, (6) focus on students' future success instead of past difficulties, (7) celebration of small steps toward success, and (8) reliance on goal-setting activities.

Utilizing a quasi-experimental pretest-posttest comparison group design, Franklin et al. (2007) compared credits earned, attendance, and graduation rates of those at-risk adolescents in the SFAS to those with similar characteristics (e.g., attendance, number of credits earned, participation in the free lunch program) in another high school in the same urban city. Data were collected and analyzed from the fall of 2002 to the spring of 2004. Overall, 46 SFAS students participated in the experimental group, and 39 students from the “regular” high school participated in the control group (Franklin et al., 2007).

The primary purpose of this study was to assess outcomes of students enrolled in a learning environment with a school-wide solution-focused philosophy compared to student outcomes in a typical school setting. Results from this study indicated that students in both schools improved in their proportion of credits earned. For the 2002-2003 school year, no significant differences were evidenced between the two groups for



credits earned. However, for the 2003-2004 school year, a significant difference was indicated between the groups, with the experimental group earning a significantly higher average proportion of credits. As reflected in the obtained ES ( $d = 0.47$ ), students at the SFAS earned nearly a half standard deviation of more credits than those in the comparison group. Regarding attendance, there was a statistically significant difference between the experimental group and the comparison group ( $d = -1.63$ ), favoring the comparison group in this area. Franklin et al. (2007) analyzed the graduation rates for students in the 12<sup>th</sup> grade during the spring of 2004 and determined that of those 37 students in the SFAS group, 23 (62%) graduated; in contrast, 27 out of 30 (90%) graduated in the comparison group.

Further examination of this study indicates several potential methodological limitations. These include a lack of random assignment to the comparison and experimental groups, a small sample size, and potential selectivity bias related to the lack of control of individual differences between those in the SFAS and those in the comparison high school. Further, researchers relied on attendance, credits earned, and graduation data from the district's database. Overall, Franklin et al. (2007) presented findings in support of the positive impact of this environment on students' credit acquisition; however, the methodological issues evidenced in their study should be considered and impact future research in this area.

**Conclusions.** Researchers have utilized SFBT with children and adolescents in elementary, middle, and high schools with various presenting concerns (e.g., academic challenges, disruptive behaviors, internalizing issues). A review of the research indicates some support for the implementation of SFBT with youth experiencing more observable,

externalizing challenges. These include behavioral difficulties that are easily detected and monitored by teachers, parents, and the youths themselves. In a systematic review of 84 studies on SFBT with children and families in various settings, Woods and Green (2011) determined that there were not only more studies on SFBT and externalizing behaviors than other problem areas, but also that those experiencing these difficulties who received the SFBT intervention may have the most successful outcomes. In single-subject research designs, Kim (2012) discussed that there are more studies on SFBT and externalizing behaviors than in any other area. However, a void is evident in the literature on school-based SFBT with students presenting with these issues and on the utilization of a single-subject methodology.

Future research may focus on delineating the effectiveness of SFBT with specific populations and problem areas and “continue using better measures as they replicate existing findings and explore new applications of SFBT in school settings” (Franklin et al., 2012, p. 243). Replication of the current studies on school-based SFBT may in turn add to the utility of its incorporation within this environment. As indicated by Franklin et al. (2012), “externalizing behaviors are particularly egregious in schools, and the positive outcomes reported in the school research by different observers (e.g., students and teachers) should be replicated and may be of great interest to both practitioners and researchers” (p. 243). An examination of the effects of SFBT on overt behavioral problems, research indicates improved outcomes for students who presented with these behaviors and participated in SFBT interventions (Franklin et al., 2008). More research in this area is required in order to provide support for the use of SFBT with externalizing behavior problems in a school setting.

**Fidelity and integrity monitoring in SFBT.** The next section provides an overview of fidelity and integrity monitoring as it relates to SFBT. Research on treatment fidelity and integrity measures in SFBT indicates that there are few developed measures. Further, even fewer are available for, have undergone psychometric testing, and are replicable. This is a limitation of SFBT research and highlights the need for more studies in this area.

In a systematic review conducted by Woods and Green (2011), researchers presented studies on SFBT, treatment outcomes indicated, and any fidelity monitoring tools incorporated in the methodologies. Overall, results indicated a lack of inclusion of fidelity instruments in many of the studies reviewed. Woods and Green highlighted that “future research on the effectiveness of SFBT should incorporate adequate fidelity monitoring of the intervention, including consideration of the rationale for inclusion or exclusion of specific SFBT therapeutic elements in specific situations” (p. 13). This lack of inclusion and/or lack of reporting of these fidelity measures within SFBT studies are criticisms indicated by other researchers in this area.

Lehmann and Patton (2012) designed and psychometrically evaluated one available SFBT fidelity measure. After a total of nine revisions, the measure was then re-constructed into two separate measures, including both a therapist and client version. These researchers utilized a time series design wherein the therapist and clients completed assessments during the third session and every subsequent three sessions. Researchers measured both internal consistency reliability and factorial validity. An overall Cronbach’s alpha coefficient of .89 was indicated for both versions of the scale

across the time series. In addition, researchers analyzed scores from the first observation in the time series, and a Cronbach's alpha coefficient of .88 was calculated.

The final version (i.e., version 10) of this fidelity measure consists of 13 items and entitled, *Solution-Focused Fidelity Instrument v.10* (Lehmann & Patton, 2012). Each item is rated using a Likert scale ranging from one (*not at all*) to seven (*yes, clearly and specifically*). To obtain information on the quality of this measure, Lehmann and Patton (2012) conducted a pilot study with graduate-level social work students. The goal of this study was "to determine whether criteria that were consistent with the underlying assumptions of SFBT could be developed into a fidelity instrument" (Lehmann & Patton, 2012, p. 49). Though these students rated themselves during the 1<sup>st</sup>, 3<sup>rd</sup>, 6<sup>th</sup>, and 9<sup>th</sup> sessions with each client, only data collected from the 6<sup>th</sup> session were analyzed. Their argument for this decision was twofold. First of all, Lehmann and Patton (2012) indicated that, "to accurately assess adherence to a given intervention, it is important to take into account the therapist's skills and proficiency in that specific intervention protocol" (p. 45). Meaning, assessment of students' adherence to the intended treatment protocol may be most accurately determined after practice and experience with conducting the services. Secondly, because the number of sessions varied with each of the graduate student's clients, these researchers decided to come up with an average of these sessions, which was determined to be six sessions.

Data from approximately 23 graduate-level social work interns were collected over the course of 18 months. These interns completed the sixth session with 116 clients. No data were missing. To examine the data, these researchers performed a confirmatory factor analysis (CFA). According to Lehmann and Patton (2012), this type of analysis

was utilized in order to determine if the 13 items were in fact measuring the construct of fidelity (i.e., adherence to SFBT). Based on the reliability analysis, a Cronbach's alpha of .83 was observed, indicating that the fidelity scale appeared to adequately measure the assumptions of SFBT. In addition to this analysis, Lehmann and Patton (2012) incorporated "a combination of chi-square and other goodness-of-fit indices...to determine the fit of the model" (p. 48). These authors noted that in order to determine the reliability of the items on the scale, the chi-square results should not be significant. The results reflected this and were determined to be non-significant. Examples of goodness-of-fit indices included in their analyses were the Goodness of Fit Index (GFI), the Adjusted Goodness of Fit Index (AGFI), the Comparative Fit Index (CFI), and the Root Mean Square Error of Approximation (RMSEA). As discussed by these researchers, all of the values for the indices should be .90 or above and the RMSEA values should be .05 or lower. Results from their analysis reflected both of these.

Overall, the results from this study indicated two findings: "(a) it was possible to develop fidelity criteria from SFBT and that (b) these same criteria could be operationalized and measured as a tool that has the potential to be used for evaluating SFBT" (Lehmann & Patton, 2012, p. 49). This measure underwent psychometric testing and was incorporated into a pilot study, adding support to its use as a SFBT fidelity measure. Though positive findings were evidenced, there were limitations that should be discussed. First, this study was conducted with social work graduate students, not experienced practitioners, and their responses may potentially differ from those with more experience in SFBT services. Secondly, because the fidelity measure was self-report, one may argue for the potential inaccuracy of the results due to possible personal

biases and skewed perceptions of skill-levels. Another limitation is reflected in the singular use of measurement tools. To address this limitation, future research may incorporate additional methods of assessment (e.g., videotaping, audiotaping, use of independent raters). Further, studies may also want to address test-retest reliability, internal consistency of the SFBT criteria, and threats to internal and external validity (Lehmann & Patton, 2012, pp. 51-52).

### **Literature Gaps and Future Directions in SFBT Research**

Based on an extensive literature review of SFBT, it appears that there are both literature gaps and areas that necessitate future development, especially regarding the application of SFBT with children and adolescents. Within the school domain, it is evident that the methodologies utilized in SFBT studies require further improvement. Researchers need to utilize more rigorous methodology, including experimental design, randomization of participants, and include treatment fidelity. Though this randomization may be challenging within a school domain, results from this design may be more substantive when determining the generalizability of the results. In addition, increasing the sample size may provide further support for the use of school-based SFBT. Fidelity and integrity monitoring is critical for future studies to incorporate into their methodologies in order to more successfully determine practitioner adherence to SFBT techniques as described in the updated manual designed by Bavelas et al. (2013). This manual is endorsed by the Solution-Focused Brief Therapy Association (SFBTA) and is a guide for practitioners providing SFBT services.

Though there is a general treatment manual on SFBT developed by Bavelas et al. (2013), future researchers may focus on developing a manual or protocol to use in a

school setting. Within this environment, SFBT “may be applied as prevention and remediation tools, as well as treatment for difficult populations” (Franklin et al., 2012, p. 243). A school environment is very different than other potential mental health domains, which may reflect a need for a more individualized treatment manual or protocol that addresses the challenges faced by school-based mental health providers. In addition, it may be useful to determine the effectiveness of SFBT at different tiers of intervention, as well as with different populations within those levels. This may then assist school-based providers when applying this type of therapy.

### **Single-Subject Research**

Single-subject research encompasses a number of strengths that provide support for its use within school-based research studies. As compared to group intervention designs, single-subject methodologies, “allow practitioners to monitor and evaluate their practice given the unique attributes of the case...[which] is lost with group research designs” (Di Noia & Tripodi, 2008, p. 13). Information gained from the analysis of a practitioner’s intervention with an identified problem or population-type may show beneficial when determining an intervention to implement with future clients exhibiting similar characteristics. However, it is important to highlight that one should be cautious of making broad generalizations.

Another strength of single case designs is that researchers are able to obtain data from different points throughout treatment. These points may include pre-intervention, baseline, intervention, post-intervention, and follow-up. A primary goal of single-subject designs in psychotherapy is to determine whether or not changes in behavior can be attributed to the therapeutic techniques applied during treatment versus alternative

influences. Thus, by collecting data at various points during treatment, researchers are able to objectively track individual progression, or lack thereof, to better understand the potential relationship between the intervention and the observed changes in behavior.

Researchers utilized single-subject methodologies to examine the appropriateness and effectiveness of specific therapies within unique settings and with identified populations. For example, a number of studies on the application of SFBT within a school environment incorporated a single case design with targeted problem areas. Single case research, as argued by Vannest, Davis, and Parker (2013), “is an extremely important tool in schools and clinical settings because the problems faced by children and individuals with disabilities are often unique” (p. 1). Furthermore, this type of methodology is reportedly applied in settings, such as schools, due to the potential relationship between the problems and more naturalistic environment. More specific and unique problems may require a single-subject methodology versus a large controlled group design due to the individualized nature of the problem behaviors.

Another positive characteristic of this design is that it enables clinicians to provide feedback to clients on progression made during therapy. As discussed by Petermann and Müller (2001), “feedback plays an important role in behavior modification by relating experiences of self-efficacy to patients. In that way, feedback is a part of therapy and can thus enhance the patients’ motivation and their compliance (with treatment)” (p. 2). The use of outcome measures and progress-monitoring tools in single-subject therapy research provides the client with a visual depiction of behavioral change, which may not be detected or shown otherwise. Also, the clinician may be more confident that the client’s behavioral changes were a direct result of the applied



therapeutic intervention. If a lack of progression or decline in behavior is evidenced following the intervention, the clinician still gains information on the utility of the intervention and potential limitations.

Other strengths indicated in single-subject research include flexibility, use with low-incidence population types, and cost-effectiveness. This type of design is flexible in that it may be applied within a vast number of settings. Research in this area suggests that it is implemented with low-incidence populations, which allows researchers to examine specific problem domains. Single-subject research is cost-effective, as compared to broader-scaled studies, and focuses an individual or small number of participants that meet certain criteria. This cost-effectiveness allows researchers who are limited in resources the opportunity to contribute to the literature irrespective of financial strains. The current study may introduce researchers and clinicians to the process of conducting single-subject research in a unique school with a specialized population.

As noted, the present study involved single-subject research with a concurrent multiple-baseline across subjects design. Strengths of multiple-baseline designs are depicted in attempts to control for maturation through continuous sampling and focusing on the concurrent measurement of behaviors; these allow for direct monitoring of behavioral change.

Though single-subject research embodies a number of strengths, there are also potential weaknesses in the design. As noted in Richards, Taylor, Ramasamy, and Richards (1999), there are specific concepts that must be demonstrated within a single-subject research design to strengthen the results indicated in these studies. These concepts include prediction, verification, replication, reliability, validity, and ethical

treatment. Each of these factors has the potential to support and/or limit the strength of the results (Richards et al., 1999).

One of the most discussed limitations in single-subject research is in the generalizability of the results. As discussed in Barlow et al. (2009), skeptics argued that there “is little basis for inferring that this therapeutic approach would be equally effective when applied to clients with similar behavior disorders (client generality) or that different therapists using this technique would achieve the same results (therapist generality)” (p. 47). Though the results may indicate benefits for those exposed, the same results may not be displayed with other subjects who are introduced to the intervention or treatment approach. This limits the external validity of the design. External validity is important to single-subject psychotherapy research due to the need to show that the causal relationship between the type of therapy and observed behavioral changes could, in fact, be generalized to other persons experiencing the same issues within that setting. One way to address this limitation is in the replication of studies conducted in this area.

Another limitation of single-subject designs in psychotherapy research is in the methodology applied in these studies. The literature on single-subject SFBT research indicates a need for methodological modifications in order to enhance the strength of these designs (Di Noia & Tripodi, 2008). One modification that must be made to future studies involving SFBT and single-subject methodologies is in the use of more reliable and valid outcome measures. In addition to this modification, single-subject studies must employ more rigorous and structured data collection techniques. This relates to the type of single-subject design (e.g., time series, multiple-baseline) as well as the number and types of measures utilized.

Limitations in relation to the internal validity of single-subject psychotherapeutic studies may also be of concern. As noted in Di Noia and Tripodi (2008), clients involved in therapy may also simultaneously receive assistance from other providers for the same problems. Thus, determining the impetus behind behavioral change becomes difficult as it may be unclear whether or not observed changes are reflective of the specific therapy employed or to external influences (e.g., other mental health professionals). This poses as a potential weakness and “introduces the internal validity threat of multiple treatment interference, the occurrence of other interventions that may account for changes observed in the problem of interest” (Di Noia & Tripodi, 2008, p. 15). Researchers should be aware of this potential threat when recruiting participants and determine that their specific therapeutic intervention does not overlap with the other intervention(s) the participant is receiving, if any. Maturation effects may also threaten the internal validity of the findings indicated in the study. These effects may reflect short-term changes (e.g., physiological fluctuations, lifestyle shifts) and/or long-term changes (e.g., learning) and thus, make it more challenging to determine if changes in the dependent variable (e.g., behavioral ratings) are attributable to the independent variable (e.g., psychotherapy intervention).

A final limitation to single-subject psychotherapy research is in the appropriateness of this research in various practice settings and with different populations. Well-designed single-subject methodologies incorporate multiple phases of data collection, which may not be feasible in environments with time-constraints. Further, “the methodology may be difficult to implement with clients who lack the ability to monitor their behavior, for example, those with cognitive impairments” (Di Noia &

Tripodi, 2008, p. 15). Certain therapies may involve more complex techniques and behavior monitoring, which may be challenging for individuals who present with limited cognitive functioning. Lastly, clients who demonstrate a lack of motivation to work on their behaviors may also not be appropriate for single case research studies due to the potential focus on behavioral progress monitoring over the course of treatment.

In addition to potential weaknesses of single-subject research, there are also potential weaknesses in multiple-baseline designs. Concerns evidenced in the literature include the required time investments (i.e., in-depth planning) and the possibility of covariance. Another potential weakness is that verification of treatment success may rely on the dependent variable levels (e.g., outcome ratings) not changing until the independent variable (e.g., SFBT) is introduced.

### **Purpose**

For the present study, the researcher sought to determine the effectiveness of SFBT on treatment outcomes in at-risk youth enrolled in an alternative school setting. Further, the researcher sought to evaluate the potential relationship between therapeutic alliance and behavioral change. An additional aim of the present study was to determine if fidelity was evidenced in the researcher's implementation of the SFBT intervention. Due to the limited amount of research on the utility of SFBT within an alternative school setting, and on the role of therapeutic alliance on adolescent treatment outcomes, it is believed that the present study may contribute to the literature in these areas. Primary, secondary, tertiary, and additional aims and research questions, and corresponding hypotheses, are described in the next sections.

## **Aims, Research Questions, and Hypotheses**

**Primary aim.** The primary aim of this study was to determine the level of change in treatment outcomes from baseline to post-intervention across six adolescent case studies. In addition, if change was demonstrated at posttest, the researcher sought to determine if it was maintained at 6-week follow-up. Eight research questions relating to the evaluation of treatment outcomes are listed below.

1a. To what extent did student-reported scores on the Outcome Rating Scale (ORS; Miller & Duncan, 2000) change from baseline to posttest?

1b. If change was evidenced in student-reported ORS scores, to what extent was it maintained at 6-week follow-up?

1c. To what extent did student-reported ratings on the Brief Problem Monitor, Youth Version (BPM-Y; Achenbach et al., 2011) change from baseline to posttest?

1d. If change was evidenced in student-reported BPM-Y ratings, to what extent was it maintained at 6-week follow-up?

1e. To what extent did parent ratings on the Brief Problem Monitor, Parent Version (BPM-P; Achenbach et al., 2011) change from baseline to posttest?

1f. If change was evidenced in parent BPM-P ratings, to what extent was it maintained at 6-week follow-up?

1g. To what extent did teacher ratings on the Brief Problem Monitor, Teacher Version (BPM-T; Achenbach et al., 2011) change from baseline to posttest?

1h. If change was evidenced in teacher BPM-T ratings, to what extent was it maintained at 6-week follow-up?

**Hypothesis.** The researcher anticipated that student-reported ratings on the ORS would reflect clinically significant change based on an ORS baseline score of < 28 (clinical cutoff for adolescents) for all student participants (Duncan, 2014). The researcher also assessed change via the reliable change index (RCI). According to Duncan, “The RCI indicates change that is greater than change, error, or maturation of the client. The RCI on the ORS is 6 points.” (p.72). This change is evidenced if there is a 6-point increase between baseline and posttest mean scores. The researcher also expected that student-reported, parent, and teacher ratings on the BPM would decrease from baseline to post-intervention and maintain these ratings at 6-week follow-up.

**Secondary aim.** The secondary aim of this study was to determine if there was a relationship between change in ORS scores and change in BPM ratings. Three research questions relating to treatment outcomes across these measures are listed below.

2a. Was there a relationship between change in student-reported scores on the ORS and change in student-reported ratings on the BPM-Y?

2b. Was there a relationship between change in student-reported scores on the ORS and change in parent ratings on the BPM-P?

2c. Was there a relationship between change in student-reported scores on the ORS and change in teacher ratings on the BPM-T?

**Hypothesis.** The researcher expected that the results indicate a relationship between changes in student-reported, parent, and teacher ratings on the BPM and changes in student-reported scores on the ORS. Specifically, the researcher anticipated a decrease in negative behavior ratings on the BPM among all raters and an increase in student-reported scores on the ORS.

**Tertiary aim.** The tertiary aim of this study was to determine the presence of therapeutic alliance and if there was a relationship between therapeutic alliance ratings and student-reported behavior ratings. Three research questions relating to the evaluation of therapeutic alliance and treatment outcomes are listed below.

3a. Was therapeutic alliance evidenced (i.e., scores 36 or higher) in student-reported scores on the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2002)?

3b. Was there a relationship between student-reported scores on the ORS and student-reported scores on the SRS?

3c. Was there a relationship between student-reported scores on the SRS and student-reported ratings on the BPM-Y?

**Hypothesis.** The researcher anticipated the results to indicate evidence in support of student-therapist alliance, as reflected in scores of 36 or higher on the SRS. It was also expected that results indicate a change in ORS scores and higher ratings on the SRS. Further, the researcher expected higher ratings on the SRS and lower scores on the BPM from baseline to post-intervention across all raters.

**Additional aims.** The present study also encompassed additional aims pertaining to fidelity monitoring. The researcher sought to determine if fidelity to SFBT was evidenced in the ratings of outside evaluators and if consistency was demonstrated between those ratings. Two research questions relating fidelity evaluation are provided below.

4a. Was adherence to SFBT indicated in the fidelity evaluation ratings from both outside evaluators?

4b. Was consistency demonstrated between those fidelity evaluation ratings?

**Hypothesis.** The researcher anticipated that the results indicate adherence to SFBT, as reflected in total scores between 65-91 on the fidelity measure based on guidelines set forth by Lehmann and Patton (2012). The researcher also expected the fidelity ratings to reflect consistency between both evaluators.



## **Chapter Two: Research Methodology**

The overall purpose of this study was to determine the effectiveness of school-based SFBT with at-risk youth in an alternative school environment. Additionally, therapeutic alliance and adherence to SFBT were evaluated. This methodology section describes: (a) research setting, (b) research participants, (c) research design, (d) instrumentation, and (e) procedures. Of note, the names of the student participants included in this study are not indicative of their actual names. The researcher randomly selected and assigned a name to each of the students.

### **Setting**

The present study was conducted in an alternative school. According to the United States Department of Education defined this type of school as:

a public elementary/secondary school that (1) addresses needs of students that typically cannot be met in a regular school, (2) provides nontraditional education, (3) serves as an adjunct to a regular school, or (4) falls outside the categories of regular, special education, or vocational education. (U.S. Department of Education, 2010, p. 61)

The county in which this school was located was considered as an “urban cluster” (UC). According to the United States Census Bureau, an “urban cluster” (UC) is defined as one that consists of densely developed territory that has at least 2,500 people, but fewer than 50,000 people (United States Census Bureau, 2010).

### **Participants**

As mentioned, the researcher utilized fictitious names for each participant as a safeguard to maintain confidentiality of identifiable data collected during the course of the study. Six enrolled adolescents between the 6<sup>th</sup>-12<sup>th</sup> grades within the identified

alternative school were included in the study. At-risk youth were referred to this alternative school by the middle schools, the high schools, the superintendent, or the judicial system within the county due to not meeting their full potential in their current educational setting. Students within the school typically exhibited emotional and/or behavioral challenges that led to their placement within this alternative environment. In addition, a parent or legal guardian of each of the six students, and a teacher of each of the six students participated in the study.

**Therapist.** A fourth-year doctoral candidate in School Psychology at the University of Kentucky provided mental health services to all students enrolled in this study. The clinician was a Caucasian female in her late-20s and had a Master of Science degree in Counseling Psychology (2010) and a Master of Science degree in School Psychology (2011); both degrees were conferred from the University of Kentucky. While in these graduate programs, she received extensive instruction on and supervision with the utilization of a number of evidence-based psychotherapies; however, her primary theoretical orientations included cognitive-behavioral therapy (CBT) and solution-focused brief therapy (SFBT). The clinician also sought out many professional development opportunities to enhance her clinical skills in the provision of mental health services to youth while completing her training. Further, she has had clinical opportunities in a variety of settings, including elementary, middle, and high schools, a university-based clinic, a community-based counseling center, and a private practice. During her clinical training experiences, she predominantly worked with children, adolescents, and young adults; these individuals differed substantially in their areas of concern and level of functioning across various domains (e.g., intellectual, academic,

adaptive behavioral, social-emotional). Her doctoral work has centered on the evaluation and treatment of children and adolescents presenting with complex developmental, intellectual, academic, social-emotional, and behavioral difficulties. The clinician was also selected for a child- and adolescent-focused predoctoral psychology internship for the 2014-2015 calendar year that was accredited by the American Psychological Association (APA).

**Participant 1.** Andrew was a 14-year-old Caucasian male in the 7<sup>th</sup> grade. Andrew was referred to this study by the principal of the alternative school, who was concerned about Andrew's emotional and behavioral functioning. Background information was collected from Andrew's social and developmental history form, which was completed by his biological mother prior to enrolling in the alternative school, as well as from the intake interview conducted by this researcher. In regard to familial dynamics, Andrew resided with his biological mother and stepfather, who had a combined annual income of less than \$6,000. Andrew was diagnosed with Attention-Deficit/Hyperactivity Disorder (AD/HD) in elementary school. He had not received any outside counseling services and was not receiving any outside counseling services at the time of this study. In regard to his academic history, Andrew was retained in the 2<sup>nd</sup> grade, was frequently in discipline trouble at school, and presented with relational difficulties with peers. Andrew was referred to the alternative school by his middle school. On the social and developmental history form, Andrew's mother endorsed that Andrew exhibited defiance (e.g., did not follow rules imposed by his parents, did not follow directions), conduct-related concerns (e.g., lied to avoid punishment or responsibility, engaged with peers who were frequently in trouble, was untrustworthy),

and verbal aggression. His mother also indicated that Andrew possessed an interest in music and sports and strengths in his verbal and leadership skills.

During the initial parent interview, Andrew's mother reported that her primary concern was Andrew's anger, which had been a concern for around five years. On a severity scale of *mild, moderate, severe, or extremely severe*, she ranked this concern as *moderate*. Her secondary concern was Andrew's defiance (e.g., "talking back"), which had been a concern for around six years. She ranked this concern as *severe*.

**Participant 2.** Bonnie was a 14-year-old Hispanic/Caucasian female in the 9<sup>th</sup> grade. Bonnie was referred to this study by one of her teachers at the alternative school, who was concerned about Bonnie's emotional and behavioral functioning. Background information was collected from Bonnie's social and developmental history form, which was completed by her biological father prior to enrolling in the alternative school, as well as from the intake interview conducted by this researcher. In regard to familial history, Bonnie resided with her father, brother, and three sisters. Bonnie's school records indicated that she was involved in the Department of Juvenile Justice (DJJ) court system due to truancy. Bonnie was referred to the alternative school by the DJJ. Parent report indicated that Bonnie had not received any outside counseling services and was not receiving any outside counseling services at the time of the study. Bonnie's father reported that Bonnie possessed a personal interest in art and music and a strength in her interaction skills with adults.

During the initial parent interview, Bonnie's father reported that his primary concern was Bonnie's truancy, which had been a concern for around two months. On a

severity scale of *mild, moderate, severe, or extremely severe*, he ranked this concern as *moderate*.

**Participant 3.** Charlie was a 17-year-old Caucasian male in the 12<sup>th</sup> grade. Charlie was referred to this study by the principal of the alternative school, who was concerned about Charlie's emotional and behavioral functioning. Background information was collected from Charlie's social and developmental history form, which was completed by his biological mother prior to enrolling in the alternative school, as well as from the intake interview conducted by this researcher. In regard to familial dynamics, Charlie resided with his biological mother, sister, and brother. Charlie's mother reported a total annual income of less than \$6,000. Charlie was diagnosed with AD/HD in elementary school. Charlie reportedly received outside counseling services in the past, but was not receiving any outside counseling services at the time of the study. Charlie was referred to the alternative school by the DJJ and was initially involved in the DJJ court system due to receiving a criminal charge for theft. On the social and developmental history form, Charlie's mother endorsed that Charlie exhibited conduct-related behaviors (e.g., lied to avoid punishment or responsibility), verbal aggression, and relational issues with peers. She also indicated that Charlie possessed an interest in sports.

During the initial parent interview, Charlie's mother reported that her primary concern was Charlie's anger, which had been a concern for around 12 years. On a severity scale of *mild, moderate, severe, or extremely severe*, she ranked this concern as *moderate*. Her secondary concern was Charlie's defiance (e.g., difficulty with being told

‘no’ by adults), which had been a concern for around four years. She ranked this concern as *severe*.

**Participant 4.** David was a 14-year-old Caucasian male in the 9<sup>th</sup> grade. David was referred to this study by the principal of the alternative school, who was concerned about David’s emotional and behavioral functioning. Background information was collected from David’s social and developmental history form, which was completed by his biological father prior to enrolling in the alternative school, as well as from the initial intake interview conducted by this researcher. In regard to familial history, David resided with his biological father and sister; his father indicated that other adults (i.e., his friends) live in the home as well. David’s father reported a total annual income of between \$30,001 and \$50,000. David reportedly had not received outside counseling services and was not receiving any outside counseling services at the time of the study. David was referred to the alternative school by the family court system due to truancy. On the social and developmental history form, David’s father endorsed that David struggled with peer relationships (e.g., “had few friends”). David reportedly possessed a personal interest in music and strengths in his likeable personality and interaction skills with adults.

During the initial parent interview, David’s father reported that his primary concern was David’s social interactions in large groups, which had been a concern for around two years. On a severity scale of *mild, moderate, severe, or extremely severe*, he ranked this concern as *severe*.

**Participant 5.** Evan was a 14-year-old Caucasian male in the 7<sup>th</sup> grade. Evan was referred to this study by the principal of the alternative school, who was concerned

about Evan's emotional and behavioral functioning. Background information was collected from Evan's social and developmental history form, which was completed by his maternal aunt (i.e., legal guardian), prior to enrolling in the alternative school, as well as from the intake interview conducted by this researcher. In regard to familial dynamics, Evan resided with his maternal aunt and uncle, grandmother, five siblings, and several cousins. Legal guardianship was awarded to Evan's aunt and uncle when Evan was in elementary school. Evan's aunt reported a total annual income of between \$15,001 and \$20,000. Evan's school records indicated that he was receiving outside counseling services at the time of the study from the Cabinet for Families and Children. He was diagnosed with AD/HD in elementary school and was taking medication to assist in managing his symptoms. Evan was referred to the alternative school by the middle school. On the social and developmental history form, Evan's aunt endorsed that Evan exhibited defiance (e.g., did not follow rules set by his parents, did not follow directions), conduct-related behaviors (e.g., lied to avoid punishment or responsibility, was untrustworthy, and stole from others), and verbal aggression. In regard to personal interests, Evan's aunt indicated that Evan enjoyed sports-related activities.

During the initial parent interview, Evan's aunt reported that her primary concern was Evan's anger, which has been concern for around four years. On a severity scale of *mild, moderate, severe, or extremely severe*, she ranked this concern as *severe*.

**Participant 6.** Finn was a 13-year-old Caucasian male in the 6<sup>th</sup> grade. Finn was referred to this study by the principal of the alternative school, who was concerned about Finn's emotional and behavioral functioning. Background information was collected from the intake interview conducted by this researcher. Information from the social and

developmental history form was unavailable. According to Finn's biological mother, Finn was diagnosed with depression and anxiety and was receiving outside counseling services at the time of the study. Finn's mother reported that her primary concern pertained to Finn's lack of adaptive coping skills (i.e., in relation to his ability to ignore his peers), which had been a concern for around six months. On a severity scale of *mild*, *moderate*, *severe*, or *extremely severe*, she ranked this concern as *severe*. Finn's mother identified his anger as a secondary concern, which had been a concern for around six months. She also ranked this concern as *severe*.

### **Instrumentation**

**Overview of data.** Descriptive data were obtained through parental or legal guardian completion of forms related to demographic characteristics of the student and family, parent or legal guardian report of his or her child's presenting difficulties and severity levels of those difficulties, and background information forms completed prior to enrolling in the school and at the time of consent for the current study. The qualitative data collected in this study were drawn from the audio-recorded intervention sessions with the student participants and both parents' and teachers' verbal reports on student participants' behavior and functioning throughout the course of the study. Quantitative data were obtained through the use of behavioral measures, a therapeutic alliance measure, and a fidelity measure.

**Behavioral measures.** The first behavioral measure that was incorporated was the Achenbach System of Empirically Based Assessment (ASEBA) Brief Problem Monitor (BPM), developed by Achenbach, McConaughy, Ivanova, and Rescorla (2011). Students, parents or legal guardians, and teachers were asked to complete the BPM at



pre-intervention, post-intervention, and 6-week follow-up. According to Achenbach (2013), the BPM, “is designed to monitor children's responses to interventions (RTIs) over periods of days, weeks, or months. It is also designed to monitor children's functioning during the course of services in special education, outpatient, inpatient, residential, and other contexts” (para. 1).

The BPM is divided into four scales, including Internalizing, Attention Problems, Externalizing, and Total Problems. Each scale produces a *T* score, with scores < 65 considered to be in the normal range and those  $\geq 65$  considered to be areas of concern. Under the Internalizing scale, the following areas are rated: worthlessness; guilt; self-consciousness; unhappiness; and worry. Under the Attention Problems scale, the informant rates the following areas: acting young; failing to finish; concentration; sitting still; impulsiveness; and inattentiveness. Under the Externalizing Problems scale, the following are rated: arguing; destroying things; disobeying at home; disobeying at school; stubbornness; temper; and threatens. In addition to these areas, if the informant finds there are other concerns not listed, they are allowed to propose and rate three additional concerns. The BPM has a parent (BPM-P), self-report (BPM-Y), and teacher (BPM-T) version, with the BPM-P and BPM-Y comprised of 19 items and the BPM-T comprised of 18 items. On each of the versions, the informant is asked to use a rating scale of zero (*not true*), one (*somewhat true*), and two (*very true*) to answer each of the items. The informants were asked to rate each item based on a specified time frame (i.e., within the past seven days).

***BPM research.*** Achenbach and Rescorla (2001) provided results on the BPM parent, teacher, and youth self-report Total Problem scale scores. Internal consistency

(Cronbach's alpha) reliability was .92 on the parent form, .90 on the teacher form, and .86 on the youth self-report form. Mean test-retest time interval for the BPM-P and BPM-Y was eight days; this interval was 16 days for the BPM-T. Test-retest reliability correlation (Pearson  $r$ ) on the parent form was .85, .93 on the teacher form, and .88 on the youth self-report form. On the other scales that make up the BPM, both the internal consistencies and test-retest reliability correlations on the parent and teacher versions equaled or exceeded .80. On the youth self-report, internal consistency scores on the Internalizing, Attention Problems, and Externalizing scales ranged from .74 to .78. Test-retest reliability correlations on these three scales ranged from .77 to .85. Regarding cross-informant correlations, on the Total Problems scale, parent-teacher inter-rater reliability was .33, parent-youth inter-rater reliability was .42, and teacher-youth inter-rater reliability was .22 (Achenbach & Rescorla, 2001).

The second measure that was utilized during the baseline sessions, intervention sessions, and 6-week follow-up sessions was the Outcome Rating Scale (ORS; Miller & Duncan, 2000). On the ORS, informants are asked to rate how they have been doing across four areas of their lives. These areas include individually (i.e., personal well-being), interpersonally (i.e., family, close relationships), socially (i.e., work, school, friendships), and overall (i.e., general sense of well-being). For each area there is a visual analog scale, a 10-centimeter line, wherein the informant makes a hash mark indicating how they are doing. Marks made to the left side on line represent low levels of functioning, and marks made to the right side indicate high levels of functioning in that specific area. Scores are calculated on each line to the nearest millimeter by using a ruler. There is a maximum score of 40. Informants completed the ORS at the beginning

of every session. In the present study, students completed the ORS at each baseline session, during each of the SFBT intervention sessions, and at the 6-week follow-up session. For adolescents, the clinical cutoff on the ORS is  $< 28$  (Duncan, 2014).

**ORS research.** A number of studies on the psychometrics of the ORS are available, with great variability in sample size and population-types within these studies. In Gillaspay and Murphy (2012), five published instrument development and validation studies and four outcome studies on the ORS were described. The psychometric studies ranged in sample size from 65-1961 and included clinical and non-clinical children, adolescents, and adults. Results from a review of both the psychometric and outcome studies found that the average Cronbach's alpha coefficients for ORS scores were .85 for clinical samples and .95 for non-clinical samples. Though test-retest time frames varied between the studies reviewed, overall, researchers determined that ORS scores "demonstrated adequate test-retest reliability" with "ORS scores...expected to be sensitive to change for clinical samples yet stable over time for nonclinical samples" (Gillaspay & Murphy, 2012, p. 82).

**Therapeutic alliance measure.** The Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2002) was utilized at the end of every session during the intervention phase. Similarly, the SRS is also divided into four domains, with the informant rating the session on each of the identified areas. These domains include relationship, goals and topics, approach or method, and overall. Like the ORS, each visual analog scale on the SRS is 10-centimeters long, and scores are calculated by using a ruler. There is also a maximum score of 40. Informants complete the SRS at the end of every session. In the present study, students completed the SRS at the end of each of the SFBT intervention sessions.

Scores of 36 or higher may reflect a stronger therapeutic alliance between the therapist and the client (Duncan, 2014).

**SRS research.** Gillaspay and Murphy (2012) also presented findings on the SRS instrument development and validity. The psychometric studies ranged in sample size from 65-1961 and included clinical and non-clinical children, adolescents, and adults. Regarding internal consistency estimates for the SRS scores, an average Cronbach's alpha coefficient of .92 was discovered.

**Fidelity measure.** The measure that was utilized to assess the therapist's adherence to SFBT was the *Solution-Focused Fidelity Instrument v.10* (Lehmann & Patton, 2012). This measure was originally designed for the therapist to complete herself; however, with permission from the authors, the wording was altered to allow for evaluation from outside raters. The fidelity measure is comprised of 13 items, ranked on a seven-point scale, and each item reflects specific SFBT strategies (see Appendix A). Higher numbers on the scale reflect greater adherence to the therapy, and a total score of 65-91 would suggest therapist adherence to SFBT assumptions. Therapists earning a five or higher on each of the scaled items are more likely to be adhering to those SFBT techniques than those rated at a lower number. A noteworthy point about the scale is that the therapist is able to examine each item independently to determine specific SFBT areas in which adherence may not be met. This may help the therapist hone in on areas that are not as strong as other demonstrated SFBT skills. The psychometrics of this instrument are discussed in the first chapter.

## **Intervention**

The intervention utilized in each of the six sessions was SFBT. A treatment protocol for each of the six sessions was guided by Bavelas et al.'s (2013) updated manual on SFBT, Trepper et al.'s (2010) treatment manual on SFBT, and session protocols included in De Jong and Berg (2008).

## **Procedures**

The principal and/or teachers within the alternative school referred student participants. Consent was obtained from the parent or legal guardian of each of the six student participants, as well as assent obtained from each student participant. In addition, consent was obtained from a teacher of each student participant.

After a student participant was enrolled in the study, he or she was randomly assigned to one of three groups. A member of the researcher's (i.e., doctoral clinician) dissertation committee conducted the random assignment. The researcher administered all baseline, posttest, and follow-up measures, and implemented the SFBT intervention. The researcher incorporated the procedures of simultaneous baselining, introducing the SFBT intervention to students after establishing a set number of baseline data points. Specifically, three of the students received the SFBT intervention after three baseline data points, another three received the SFBT intervention after establishing four baseline data points, and the final three received the SFBT intervention after establishing five baseline data points. The time frame in between baseline data points was two to three days.

According to Franklin et al. (2012), "solution-focused brief therapy may produce quick results when applied in schools" and results of the reviewed studies "revealed about four to eight sessions of SFBT were delivered and achieved favorable outcomes"

(p. 242). Thus, in the present study, all students received a total of six SFBT intervention sessions, following baseline. These sessions were provided an average of twice per week and varied in length.

At baseline, post-intervention, and 6-week follow-up, outcome data were collected from the student, a parent(s) or legal guardian, and a teacher using the BPM youth, parent, and teacher versions of this assessment. Outcome data were also collected from the student during each meeting, including during the baseline sessions, intervention sessions, and follow-up session using the ORS. To assess therapeutic alliance, students completed the SRS at the end of each of the SFBT intervention sessions.

To assess fidelity, two outside evaluators reviewed 12 randomly assigned SFBT sessions. Sessions three, four, five, and six from all students participants were eligible to be rated. Evaluators completed a fidelity instrument following review of each randomly selected session. All of the intervention sessions were audio-recorded, which allowed the recruited evaluators to review the designated sessions in their entirety.

**Overview of measures administered.** Table 2 presents an outline of the measures utilized in the study, including the frequency of administration for each of the six participants.

Table 2

*Measures and Frequency of Administration*

Measure	Baseline	Intervention	Post-Intervention	6-Week Follow-Up	Total
Outcome Rating Scale (ORS)	3-5	6	0	1	10-12
Session Rating Scale (SRS)	0	6	0	0	6
Brief Problem Monitor–Parent (BPM-P)	1	0	1	1	3
Brief Problem Monitor–Teacher (BPM-T)	1	0	1	1	3
Brief Problem Monitor–Youth (BPM-Y)	1	0	1	1	3

*Note.* The numbers in each of the columns represent the number of times each measure was administered to specific participants. The total number administered for student participants varied depending on their random assignment within the three baseline conditions.

## Chapter Three: Results

### Results

All data (i.e., descriptive, quantitative, and qualitative) for the present study are kept confidential in accordance with the University of Kentucky Office of Research Integrity's standards for collection and storage of electronic data (2011). All data are kept on a personal password protected computer, with reported identifiable data (e.g., name of student, parent, or teacher) stored separately from outcome data obtained in an encrypted password protected file. All participants were alerted of the potential risks and benefits of the study, as well as other study characteristics in the informed consent documents. Participants were made aware of continued therapy options for the students following the conclusion of the study.

As indicated in Table 3, the present study included primary, secondary, tertiary, and additional research questions. Primary questions pertained to baseline-posttest behavioral change and maintenance at 6-week follow-up. Secondary questions involved comparisons between outcome ratings across measures utilized in the study. Tertiary questions related to the presence of therapeutic alliance and the relationship between alliance and treatment outcomes. Additional research questions pertained to adherence to SFBT through fidelity monitoring evaluation and the level of consistency between fidelity ratings of outside evaluators.



Table 3

*Primary, Secondary, Tertiary, and Additional Aims and Research Questions*

<b><i>Primary Aims and Research Questions: PRE-POST Change and FOLLOW-UP Maintenance</i></b>	
1a.	To what extent did student-reported scores on the Outcome Rating Scale (ORS; Miller & Duncan, 2000) change from baseline to posttest?
1b.	If change was evidenced in student-reported ORS scores, to what extent was it maintained at 6-week follow-up?
1c.	To what extent did student-reported ratings on the Brief Problem Monitor, Youth Version (BPM-Y; Achenbach et al., 2011) change from baseline to posttest?
1d.	If change was evidenced in student-reported BPM-Y ratings, to what extent was it maintained at 6-week follow-up?
1e.	To what extent did parent ratings on the Brief Problem Monitor, Parent Version (BPM-P; Achenbach et al., 2011) change from baseline to posttest?
1f.	If change was evidenced in parent BPM-P ratings, to what extent was it maintained at 6-week follow-up?
1g.	To what extent did teacher ratings on the Brief Problem Monitor, Teacher Version (BPM-T; Achenbach et al., 2011) change from baseline to posttest?
1h.	If change was evidenced in teacher BPM-T ratings, to what extent was it maintained at 6-week follow-up?
<b><i>Secondary Aims and Research Questions: Comparison of Outcome Ratings</i></b>	
2a.	Was there a relationship between change in student-reported scores on the ORS and change in student-reported ratings on the BPM-Y?
2b.	Was there a relationship between change in student-reported scores on the ORS and change in parent ratings on the BPM-P?
2c.	Was there a relationship between change in student-reported scores on the ORS and change in teacher ratings on the BPM-T?
<b><i>Tertiary Aims and Research Questions: Therapeutic Alliance and Outcome Ratings</i></b>	
3a.	Was therapeutic alliance evidenced (i.e., scores 36 or higher) in student-reported scores on the SRS?
3b.	Was there a relationship between student-reported scores on the ORS and student-reported scores on the SRS?
3c.	Was there a relationship between student-reported scores on the SRS and student-reported ratings on the BPM-Y?
<b><i>Additional Aims and Research Questions: Fidelity Monitoring</i></b>	
4a.	Was adherence to SFBT indicated in the fidelity evaluation ratings from both outside evaluators?
4b.	Was consistency demonstrated between those fidelity evaluation ratings?

*Notes.* ORS = Outcome Rating Scale (Miller & Duncan, 2000). BPM-Y, BPM-P, and BPM-T = Achenbach System of Empirically Based Assessment Brief Problem Monitor, Youth, Parent, and Teacher Versions (Achenbach et al., 2011). SRS = Session Rating Scale (Miller, Duncan, & Johnson, 2002).

## Overview of Non-Regression Analyses

Data were analyzed using non-regression approaches and visual analyses. As discovered by Campbell (2004), when compared to non-regression effect sizes, regression-based ESs did not improve understanding of single-subject data, were more challenging to interpret intuitively, and required more time to calculate. Examples of non-regression approaches include percentage of non-overlapping data (PND), standard mean difference (SMD), and percentage exceeding the mean (PEM). Visual analyses may depict descriptive data, variability, and changes in the single-subject data.

According to Scruggs, Mastropieri, and Casto (1987), “systematic analysis of components of single-subject graphic displays revealed that a most important evaluative criterion of an effective outcome is the percentage of overlapping data displayed between treatment and baseline” (p. 27). The PND is calculated by determining the number of intervention data points that do not overlap with the highest or lowest baseline data point, depending on whether the behavior is increasing or decreasing, and divides that number by the total number of data points in the intervention phase. PND scores of 90% or higher are viewed as *very effective*, scores between 70%-89% are viewed as *effective*, and scores less than 70% are viewed as *questionable or ineffective*. (Scruggs et al., 1987; Scruggs & Mastropieri, 1998)

SMD is calculated by subtracting the mean of the baseline phase from the mean of the intervention phase. This number is then divided by the standard deviation of baseline data points. The SMD is likened to an ES and analyzed based on Cohen’s (1988) interpretation, with a small ES of  $d = 0.2$  a medium ES of  $d = 0.5$ , and a large ES of  $d = 0.8$ .

The PEM score has a range of zero to one and is also interpreted like an ES. In order to calculate PEM scores, a horizontal median line must be drawn through the baseline phase and continue through the treatment phase. The percentage of data points that fall above the median line is calculated for studies on increasing behavioral ratings, and the percentage of data points that fall below the median line is calculated for studies with a focus on reduction in behavioral ratings (Ma, 2006).

### **Outcome Data Analyses**

In this section, all primary (i.e., 1a, 1b, 1c, 1d, 1e, 1f, 1g, and 1h) and secondary (i.e., 2a, 2b, and 2c) aims and research questions are addressed for each student participant.

Table 4 presents a summary of the ORS mean ( $M$ ) at baseline and posttest, the ORS standard deviation ( $SD$ ) at baseline, change in means from baseline to posttest, whether reliable change was evidenced based on the reliable change index guideline (RCI; 6-point change between baseline-posttest mean scores) and whether or not the change was clinically significant based on an ORS baseline score of  $<28$  for all student participants. Preliminary results indicated that four out of six students exhibited reliable change based on the RCI guideline (i.e., 6-point change in baseline to post mean scores). Four out of six students also demonstrated clinically significant change based on a mean baseline ORS score of  $<28$ .

Table 4

*Level of Change in ORS Scores for All Student Participants*

Student	Baseline ORS Mean ( <i>M</i> )	Posttest ORS Mean ( <i>M</i> )	Baseline Standard Deviation ( <i>SD</i> )	Change	Reliable Change (+ 6 points from Baseline to Posttest)	Clinically Significant Change (Baseline ORS Mean of <28)
Andrew	24.3	33.6	2.35	9.3	Yes	Yes
Bonnie	29.27	34.47	0.76	5.2	No	No
Charlie	22.7	33.05	3.55	10.35	Yes	Yes
David	25.67	33.42	0.96	7.75	Yes	Yes
Evan	18.86	31.57	4.16	12.71	Yes	Yes
Finn	29.88	32.25	7.80	2.37	No	No

*Note.* ORS = Outcome Rating Scale (Miller & Duncan, 2000).

**Participant 1: Andrew.** The four graphs in Figure 1 (a) represent the BPM cross-informant T-scores on each of the four domains from baseline-posttest. No follow-up data were collected for Andrew. The domains include: (a) Internalizing, (b) Attention Problems, (c) Externalizing, and (d) Total Problems. Results on the Total Problems domain indicated a decrease in ratings to below the clinical cutoff ( $T = \geq 65$ ) from baseline-posttest for Andrew and his teacher. Parent report also indicated a decrease at posttest; however, this score remained slightly above the clinical cutoff.

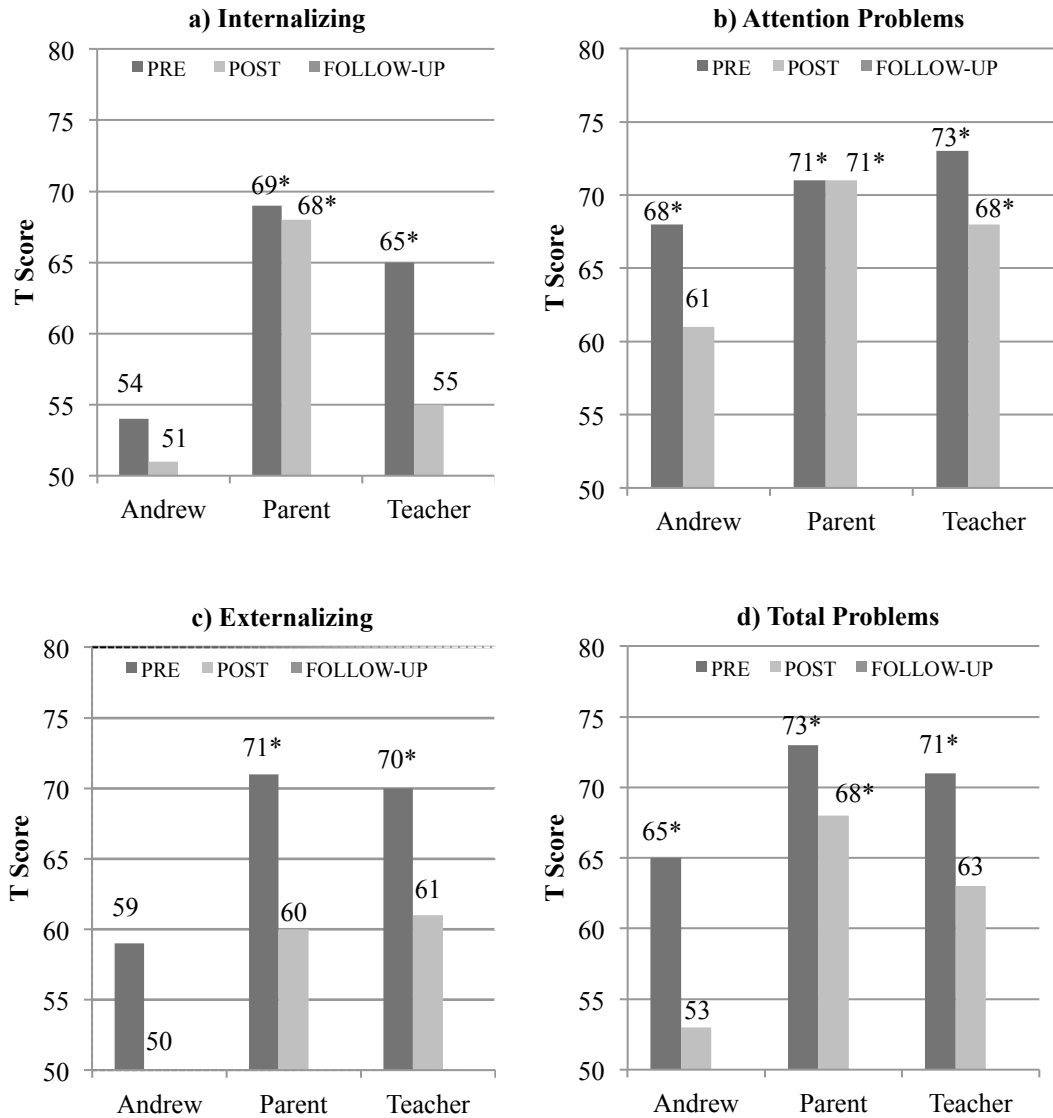


Figure 1 (a). BPM cross-informant bar graphs for Andrew. \* $T = \geq 65$  (at or above clinical cutoff).

The BPM cross-informant trajectory graphs in Figure 1 (b) reflect a visual depiction of scores for each rater (i.e., parent, teacher, and youth) within each of the four domains for Andrew across two time points (i.e., baseline and posttest).

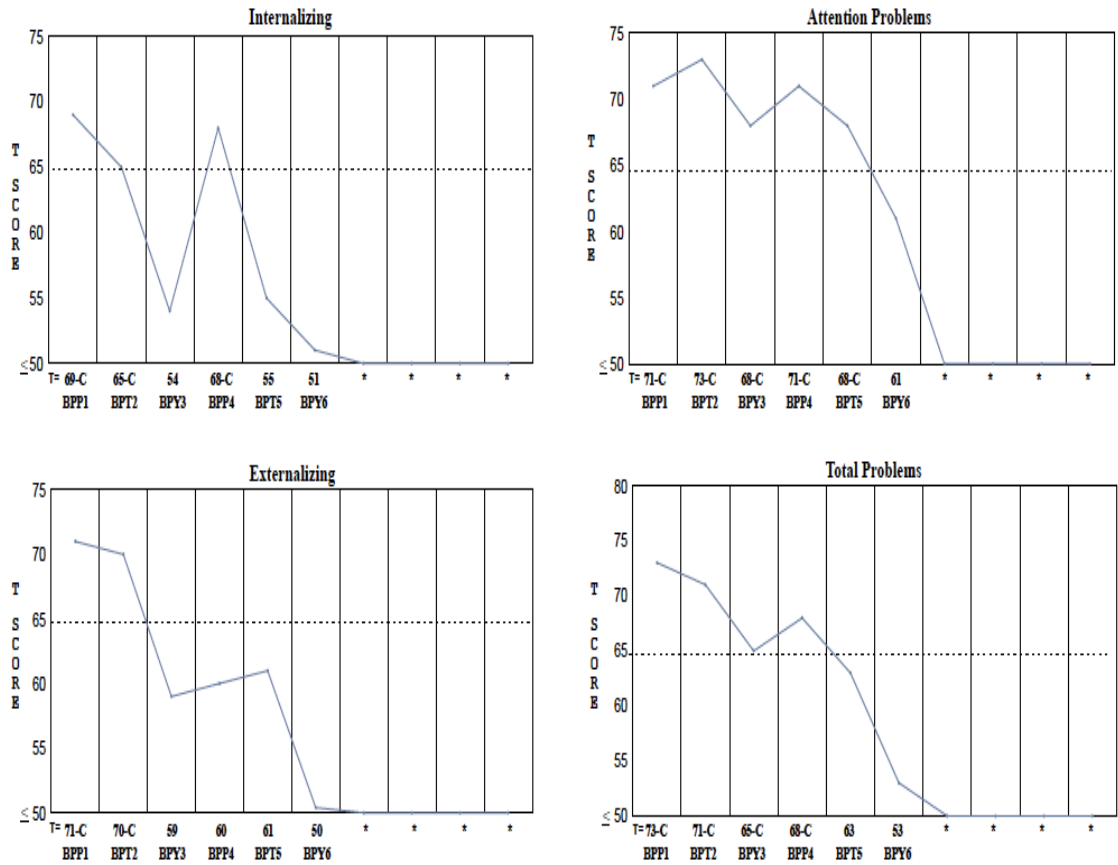


Figure 1 (b). BPM cross-informant trajectory graphs for Andrew. BPY, BPP, and BPT = Brief Problem Youth, Parent, and Teacher (Achenbach et al., 2011). Copyright 2001 by T. Achenbach. Reprinted with permission.

Figure 2 (a) presents an analysis of Andrew's ORS scores using PND. Results indicated that 83% of his intervention scores were above his highest baseline ORS score. Thus, the intervention is considered as *effective*.

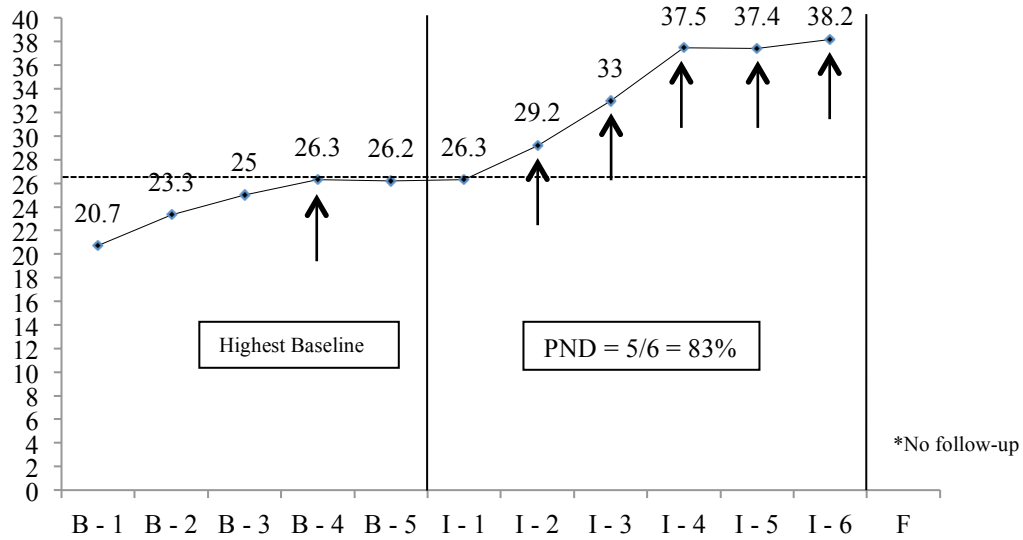


Figure 2 (a). Analysis of Andrew's ORS scores using PND.

Figure 2 (b) provides an analysis of Andrew's ORS scores using SMD. Results indicated a large ES ( $d = 3.96$ ).

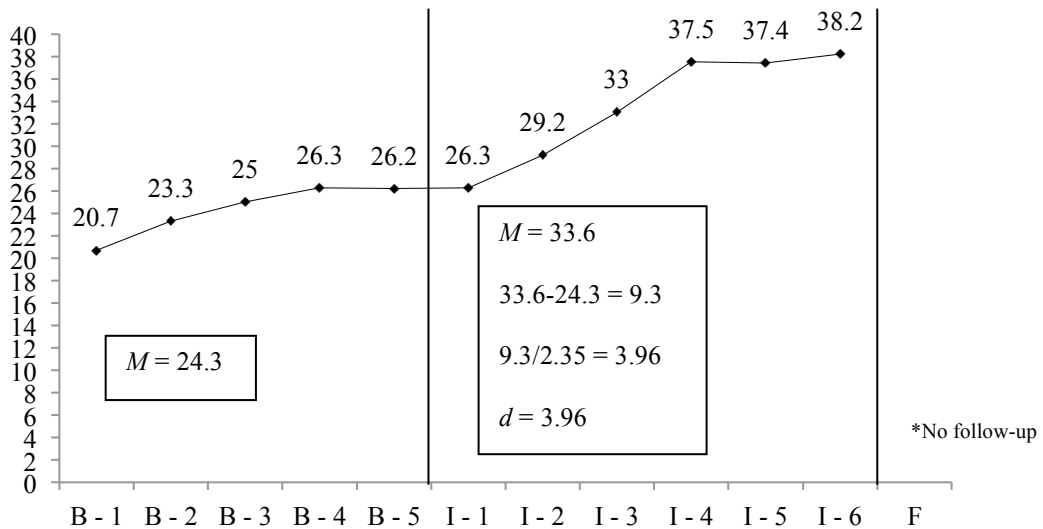


Figure 2 (b). Analysis of Andrew's ORS scores using SMD.

Figure 2 (c) reflects an analysis of Andrew's ORS scores using PEM. Results indicated that 100% of Andrew's intervention ORS scores were above the baseline median ORS score ( $Mdn = 25$ ).

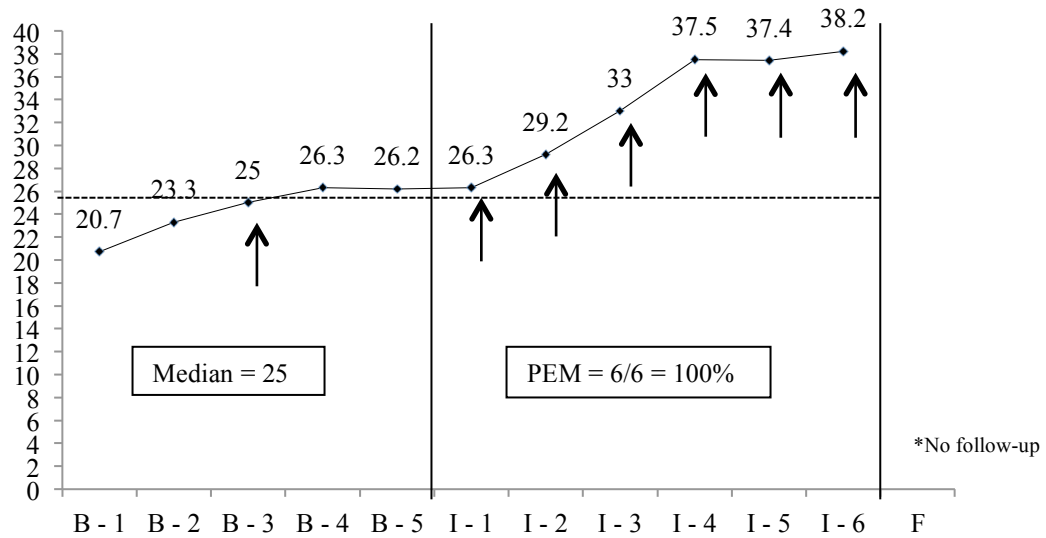


Figure 2 (c). Analysis of Andrew's ORS scores using PEM.



**Participant 2: Bonnie.** The four graphs in Figure 3 (a) represent the BPM cross-informant T-scores for each of the four domains at baseline and posttest, as well as at 6-week follow-up. The domains include: (a) Internalizing, (b) Attention Problems, (c) Externalizing, and (d) Total Problems. Results on the Total Problems domain indicated a decrease in ratings to below the clinical cutoff ( $T = \geq 65$ ) from baseline to posttest for all raters. Ratings maintained or decreased at 6-week follow-up.

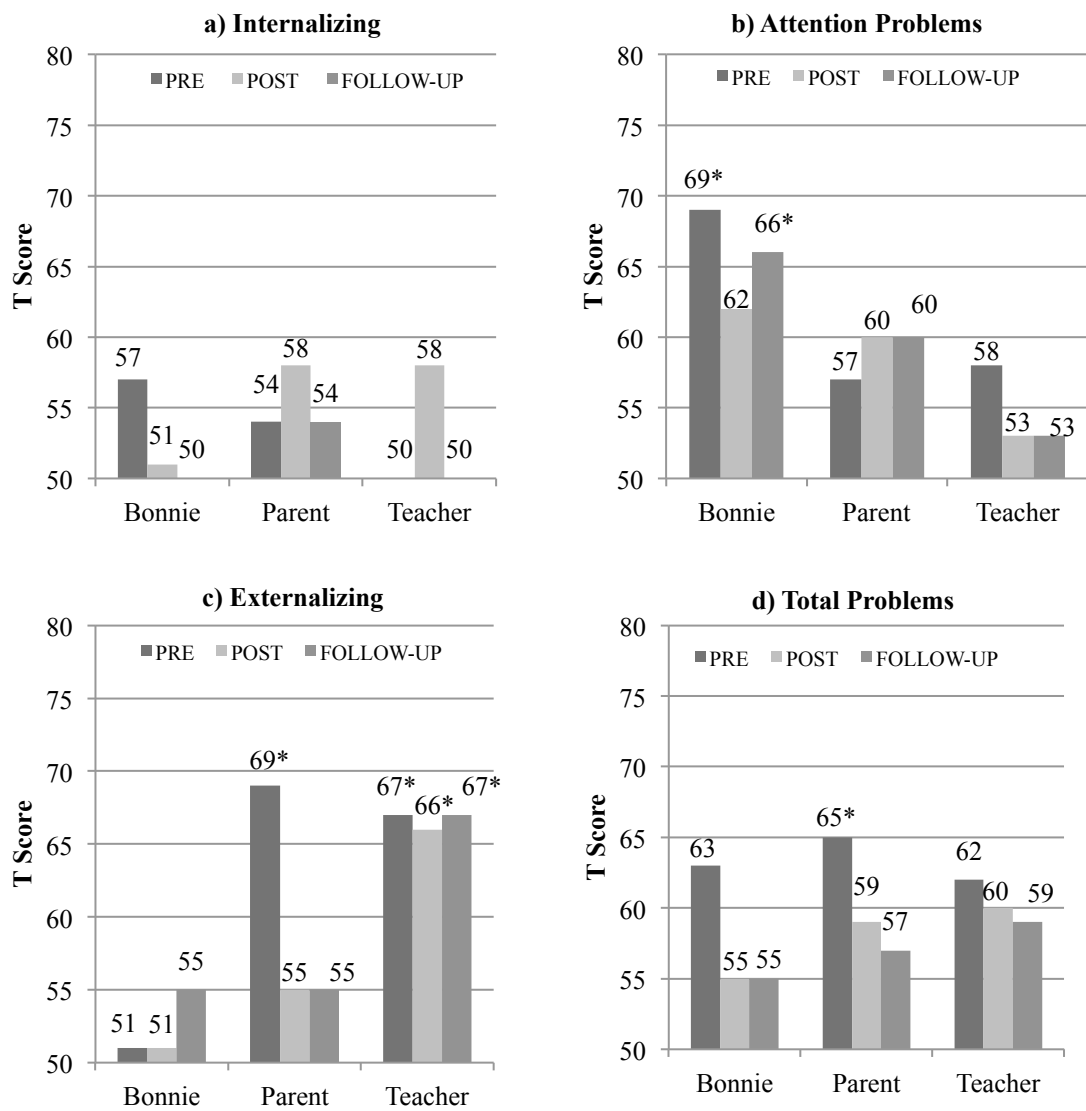


Figure 3 (a). BPM cross-informant bar graphs for Bonnie. \* $T = \geq 65$  (at or above clinical cutoff).

The BPM cross-informant trajectory graphs in Figure 3 (b) reflect a visual depiction of scores for each rater (i.e., parent, teacher, and youth) within each of the four domains for Bonnie across three time points (i.e., baseline, posttest, 6-week follow-up).

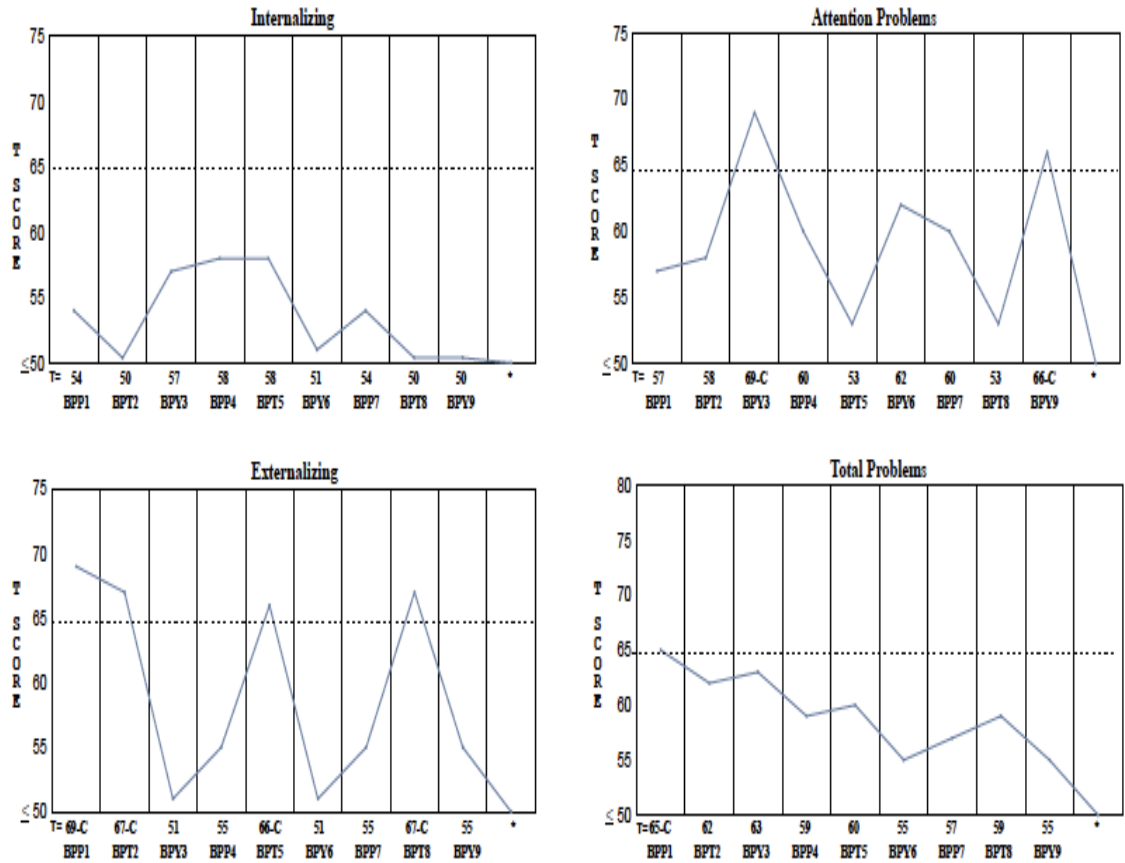


Figure 3 (b). BPM cross-informant trajectory graphs for Bonnie. BPY, BPP, and BPT = Brief Problem Youth, Parent, and Teacher (Achenbach et al., 2011). Copyright 2001 by T. Achenbach. Reprinted with permission.

Figure 4 (a) presents an analysis of Bonnie’s ORS scores using PND. Results indicated that 100% of her intervention scores were above her highest baseline ORS score. Thus, the intervention is considered *very effective*.

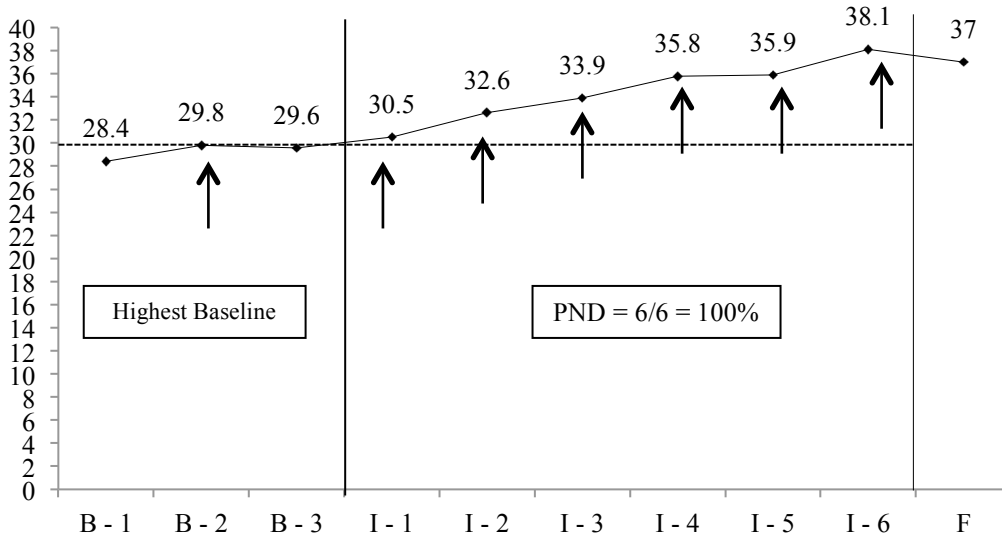


Figure 4 (a). Analysis of Bonnie’s ORS scores using PND.

Figure 4 (b) provides an analysis of Bonnie’s ORS scores using SMD. Results indicated a large ES ( $d = 6.82$ ).

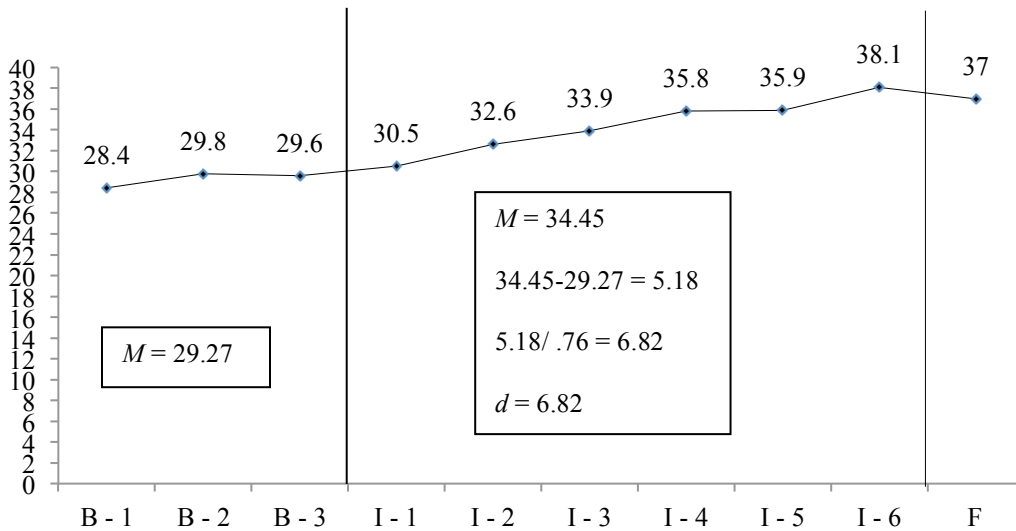


Figure 4 (b). Analysis of Bonnie’s ORS scores using SMD.

Figure 4 (c) reflects an analysis of Bonnie's ORS scores using PEM. Results indicated that 100% of Bonnie's intervention scores were above the baseline median ORS score ( $Mdn = 29.6$ ).

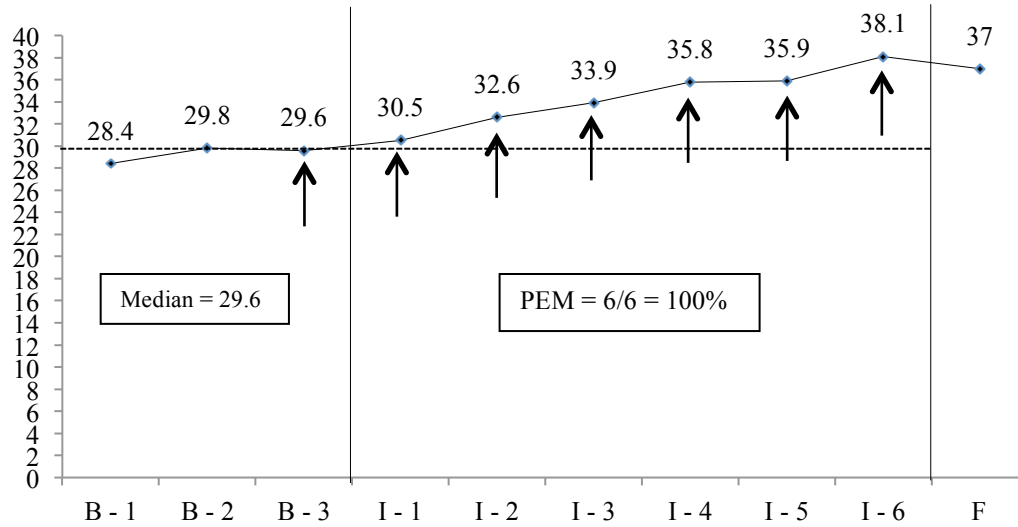


Figure 4 (c). Analysis of Bonnie's ORS scores using PEM.

**Participant 3: Charlie.** The four graphs in Figure 5 (a) represent the BPM cross-informant T-scores for each of the four domains at baseline and posttest, as well as at 6-week follow-up. The domains include: (a) Internalizing, (b) Attention Problems, (c) Externalizing, and (d) Total Problems. Results on the Total Problems domain indicated a decrease in ratings to below the clinical cutoff ( $T \geq 65$ ) from baseline to posttest for Charlie and his mother. Teacher ratings indicated a posttest score at the clinical cutoff. All ratings decreased even more at 6-week follow-up.

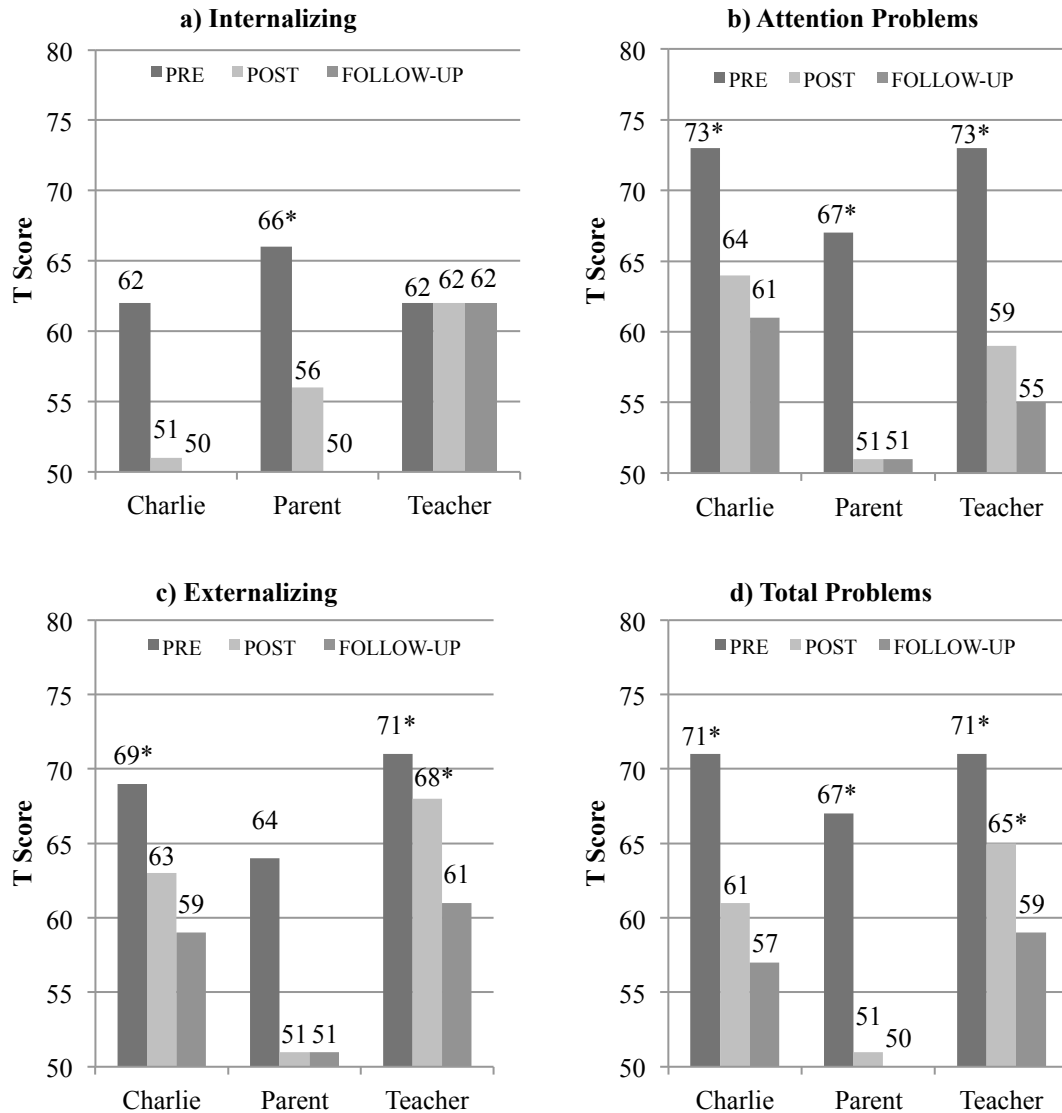


Figure 5 (a). BPM cross-informant bar graphs for Charlie. \* $T \geq 65$  (at or above clinical cutoff).

The BPM cross-informant trajectory graphs in Figure 5 (b) reflect a visual depiction of scores for each rater (i.e., parent, teacher, and youth) within each of the four domains for Charlie across three time points (i.e., baseline, posttest, 6-week follow-up).

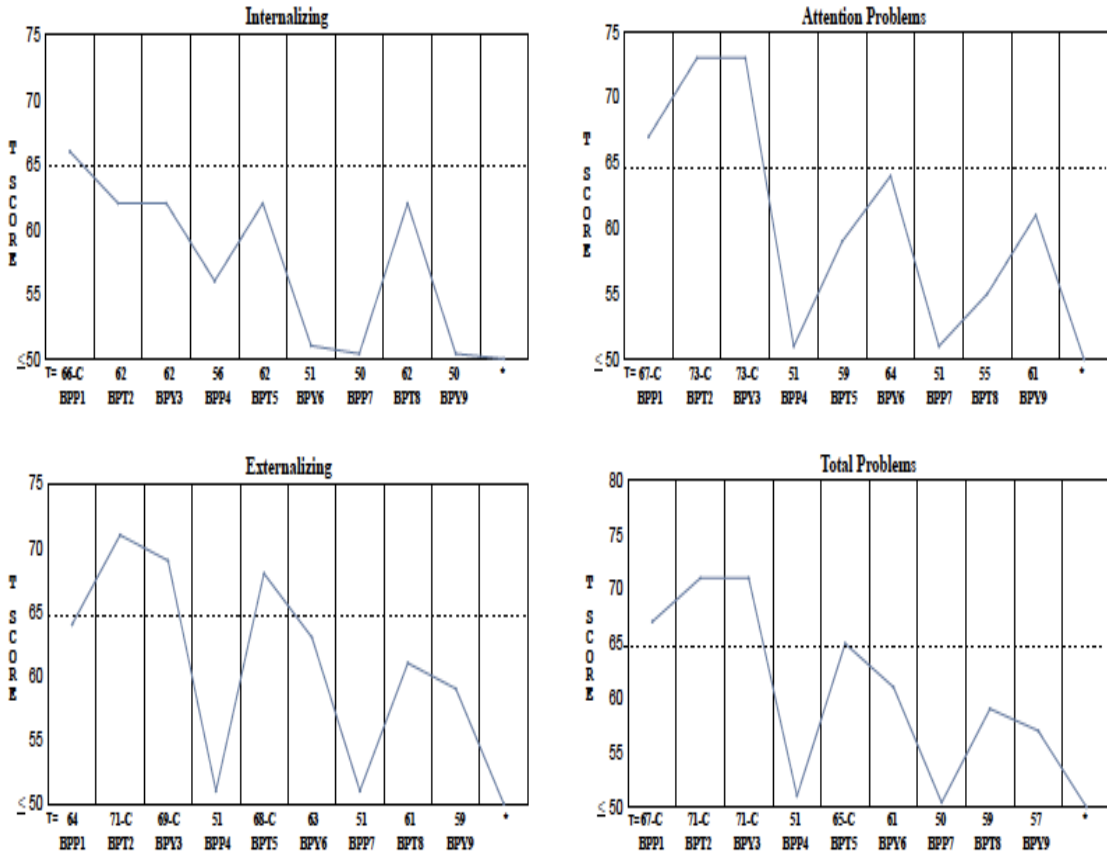


Figure 5 (b). BPM cross-informant trajectory graphs for Charlie. BPY, BPP, and BPT = Brief Problem Youth, Parent, and Teacher (Achenbach et al., 2011). Copyright 2001 by T. Achenbach. Reprinted with permission.

Figure 6 (a) presents an analysis of Charlie’s ORS scores using PND. Results indicated that 100% of his intervention scores were above his highest baseline ORS score. Thus, the intervention is considered *very effective*.

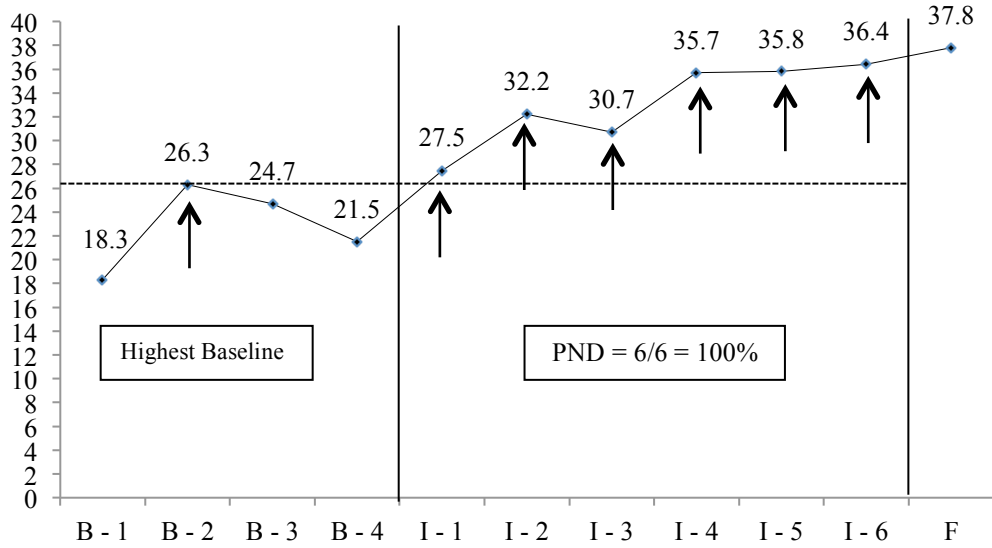


Figure 6 (a). Analysis of Charlie’s ORS scores using PND.

Figure 6 (b) provides an analysis of Charlie’s ORS scores using SMD. Results indicated a large ES ( $d = 2.92$ ).

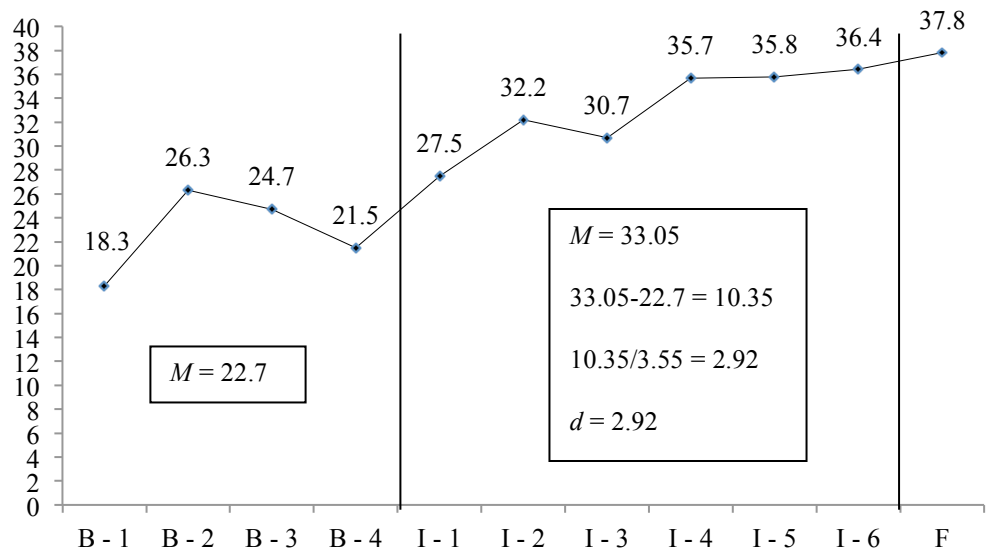


Figure 6 (b). Analysis of Charlie’s ORS scores using SMD.

Figure 6 (c) reflects an analysis of Charlie's ORS scores using PEM. Results indicated that 100% of Charlie's intervention scores were above the baseline median ORS score ( $Mdn = 23.1$ ).

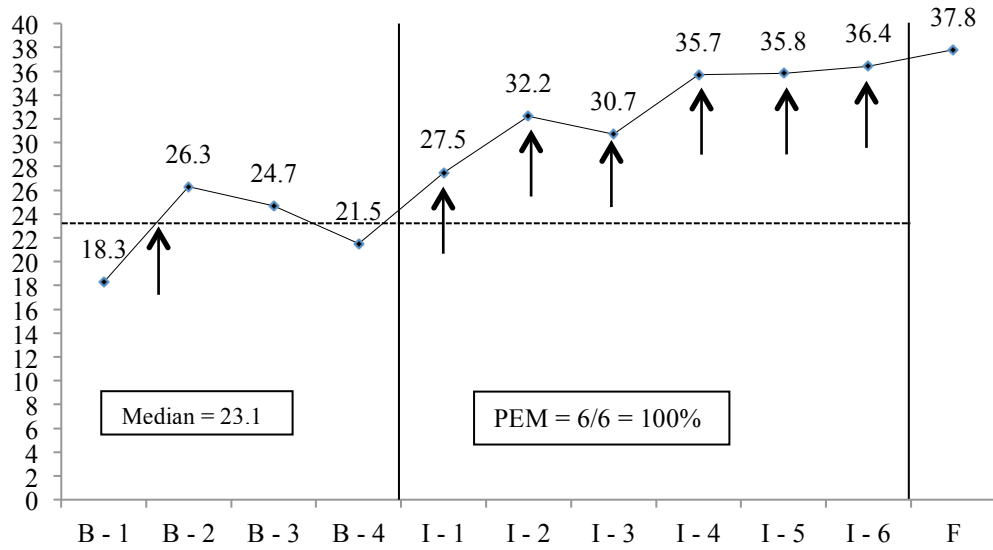


Figure 6 (c). Analysis of Charlie's ORS scores using PEM.



**Participant 4: David.** The four graphs in Figure 7 (a) represent the BPM cross-informant T-scores for each of the four domains at baseline and posttest, as well as at 6-week follow-up. The domains include: a) Internalizing, (b) Attention Problems, (c) Externalizing, and (d) Total Problems. Results on the Total Problems domain indicated a decrease in ratings to below the clinical cutoff ( $T = \geq 65$ ) from baseline to posttest for all raters. Ratings maintained or decreased at 6-week follow-up.

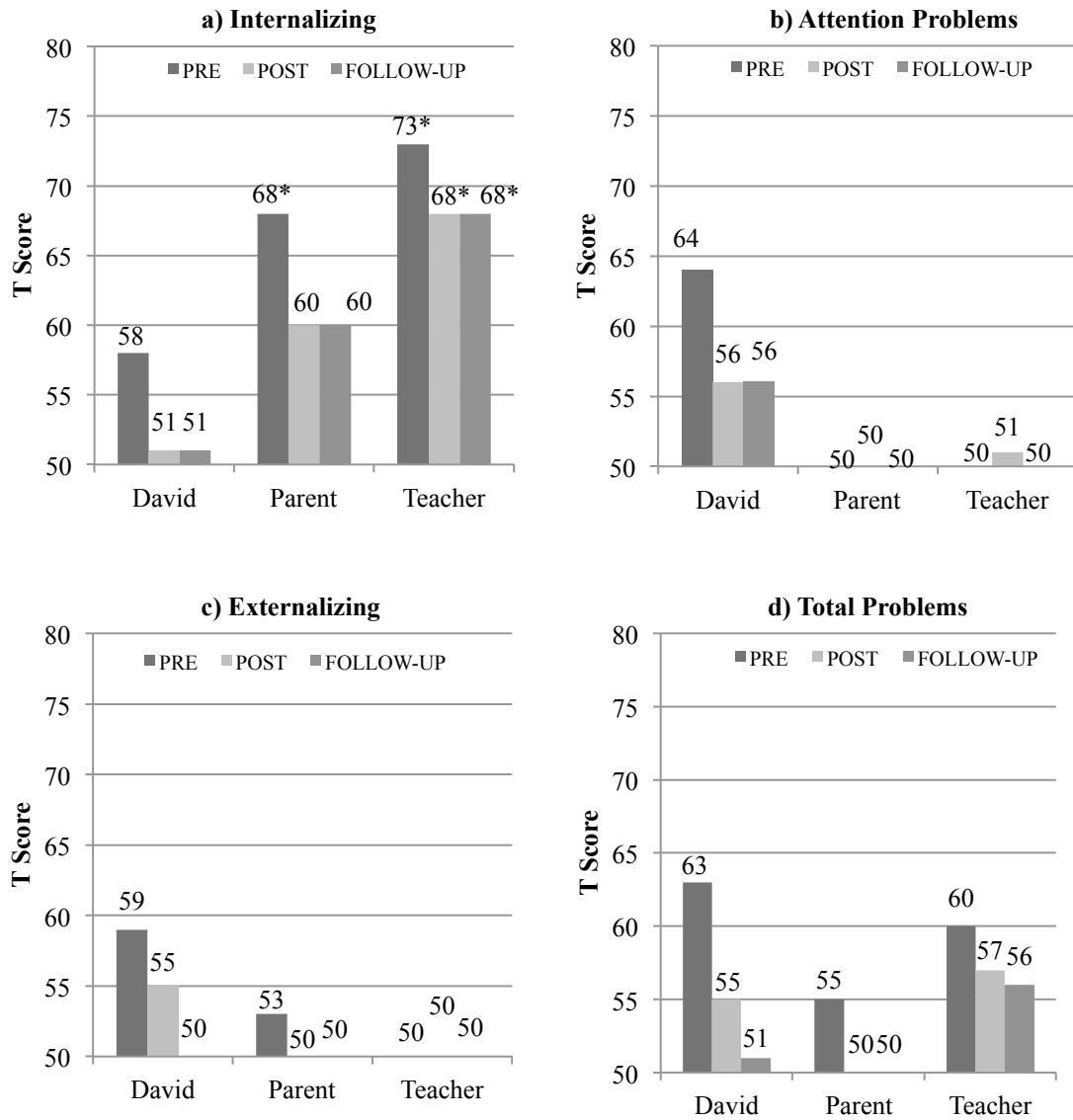


Figure 7 (a). BPM cross-informant bar graphs for David. \* $T = \geq 65$  (at or above clinical cutoff).

The BPM cross-informant trajectory graphs in Figure 7 (b) reflect a visual depiction of scores for each rater (i.e., parent, teacher, and youth) within each of the four domains for David across three time points (i.e., baseline, posttest, 6-week follow-up).

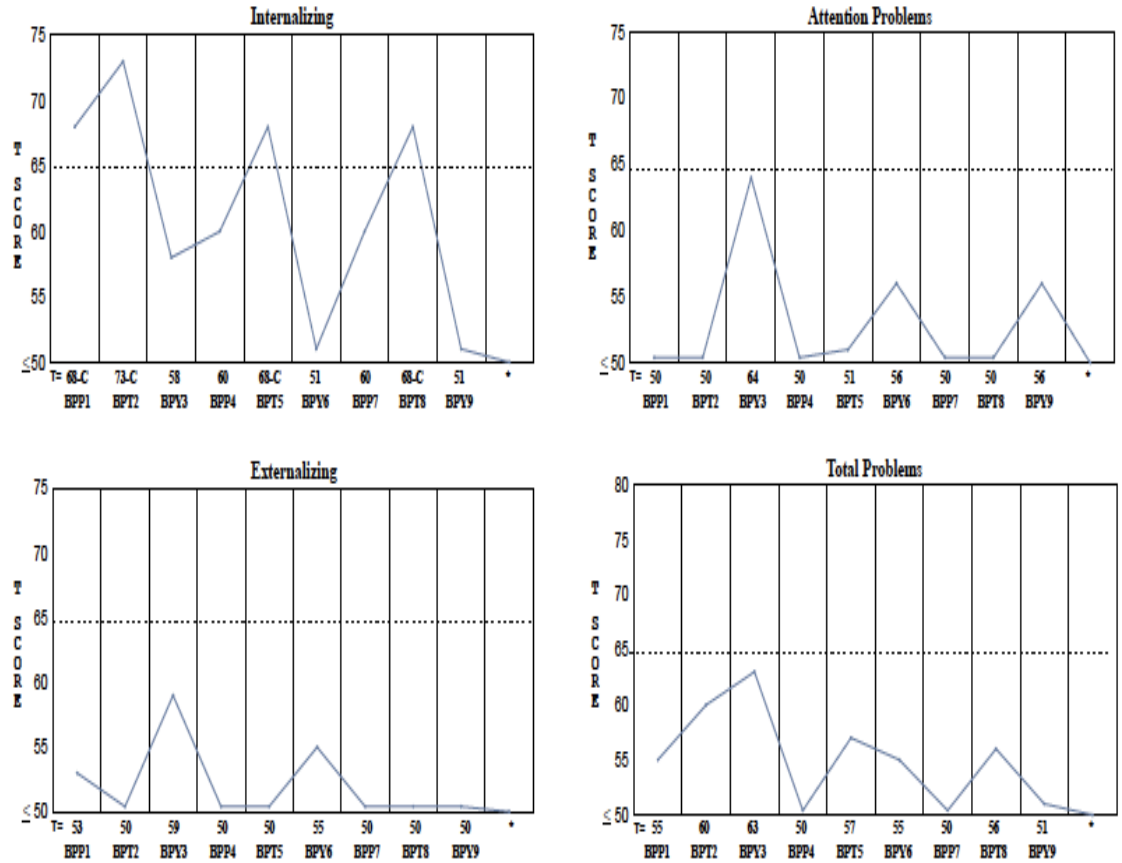


Figure 7 (b). BPM cross-informant trajectory graphs for David. BPY, BPP, and BPT = Brief Problem Youth, Parent, and Teacher (Achenbach et al., 2011). Copyright 2001 by T. Achenbach. Reprinted with permission.

Figure 8 (a) presents an analysis of David's ORS scores using PND. Results indicated that 83% of his intervention scores were above his highest baseline ORS score. Thus, the intervention is considered *effective*.

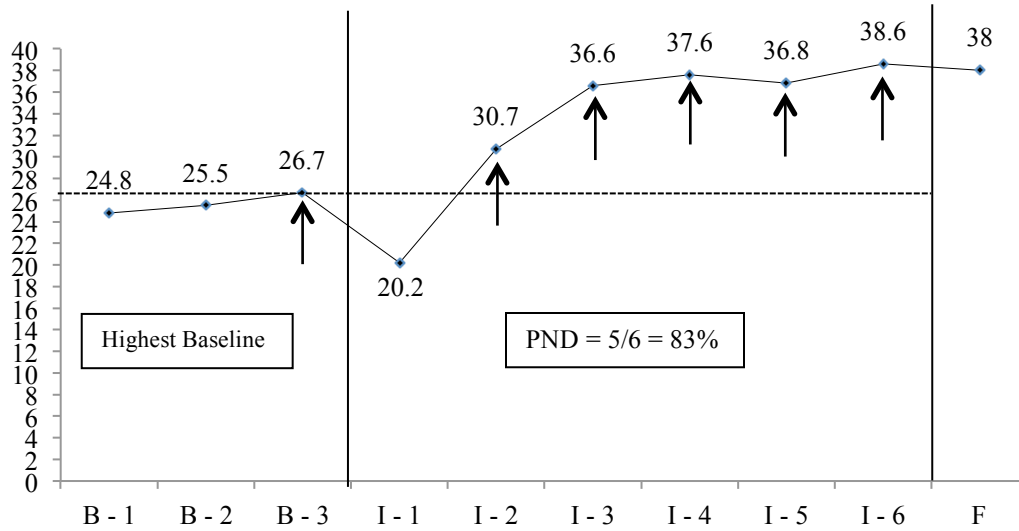


Figure 8 (a). Analysis of David's ORS scores using PND.

Figure 8 (b) provides an analysis of David's ORS scores using SMD. Results indicated a large ES ( $d = 8.07$ ).

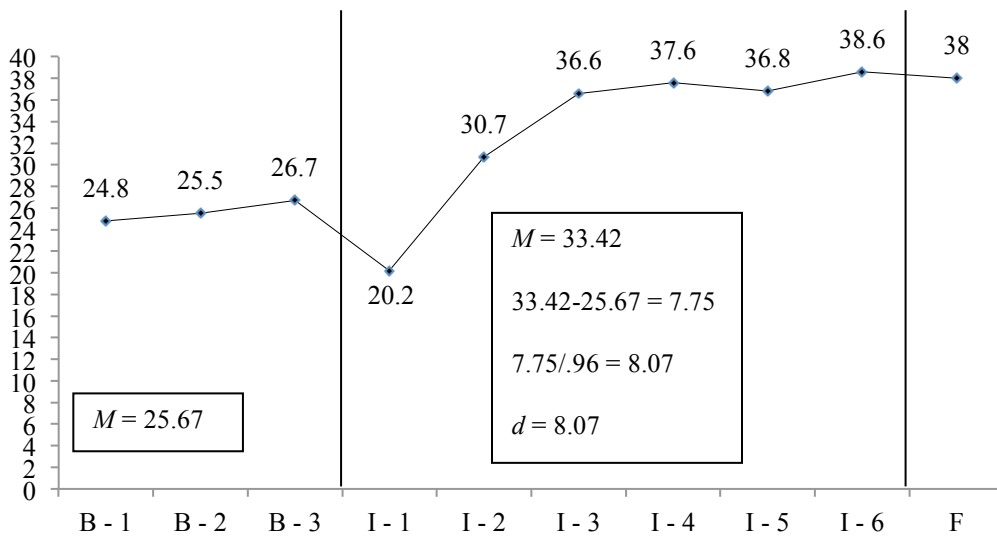


Figure 8 (b). Analysis of David's ORS scores using SMD.

Figure 8 (c) reflects an analysis of David's ORS scores using PEM. Results indicated that 83% of David's intervention scores were above the baseline median ORS score ( $Mdn = 25.5$ ).

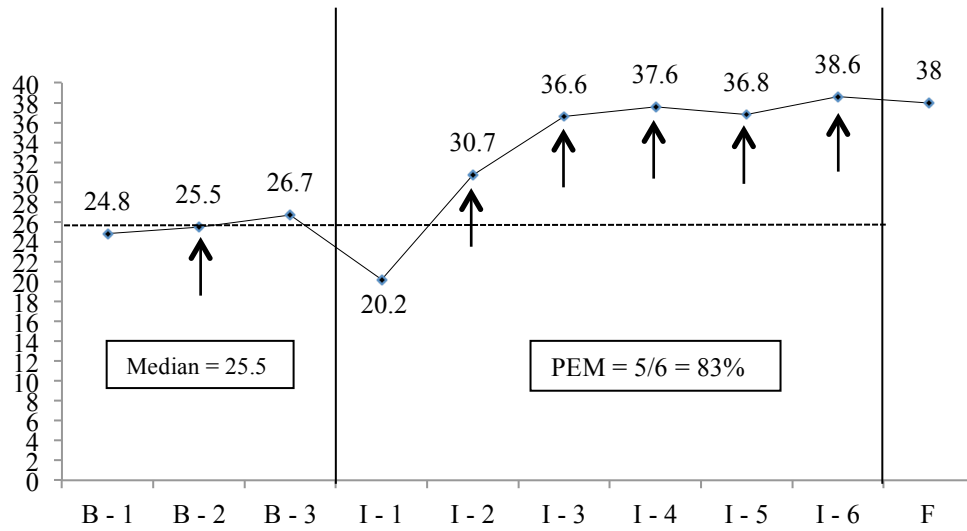


Figure 8 (c). Analysis of David's ORS scores using PEM.

**Participant 5: Evan.** The four graphs in Figure 9 (a) represent the BPM cross-informant T-scores for each of the four domains at baseline and posttest. No follow-up data were collected for Evan. The domains include: (a) Internalizing, (b) Attention Problems, (c) Externalizing, and (d) Total Problems. Results on the Total Problems domain indicated a decrease in ratings to below the clinical cutoff ( $T = \geq 65$ ) from baseline-posttest for Evan and his parent. Teacher report indicated a decrease at posttest; however, this score remained slightly above the clinical cutoff.

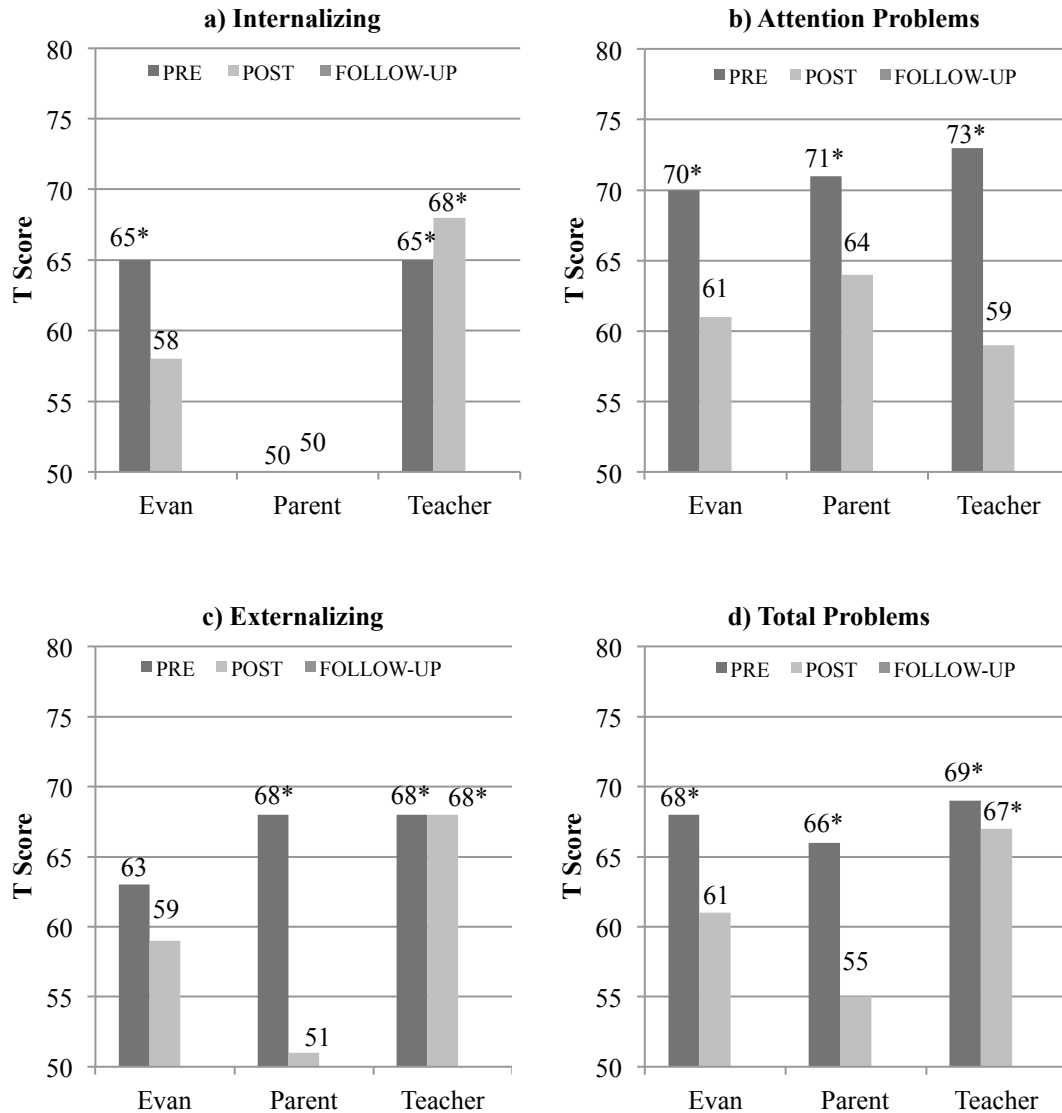


Figure 9 (a). BPM cross-informant bar graphs for Evan. \* $T = \geq 65$  (at or above clinical cutoff).

The BPM cross-informant trajectory graphs in Figure 9 (b) reflect a visual depiction of scores for each rater (i.e., parent, teacher, and youth) within each of the four domains for Evan across two time points (i.e., baseline and posttest).

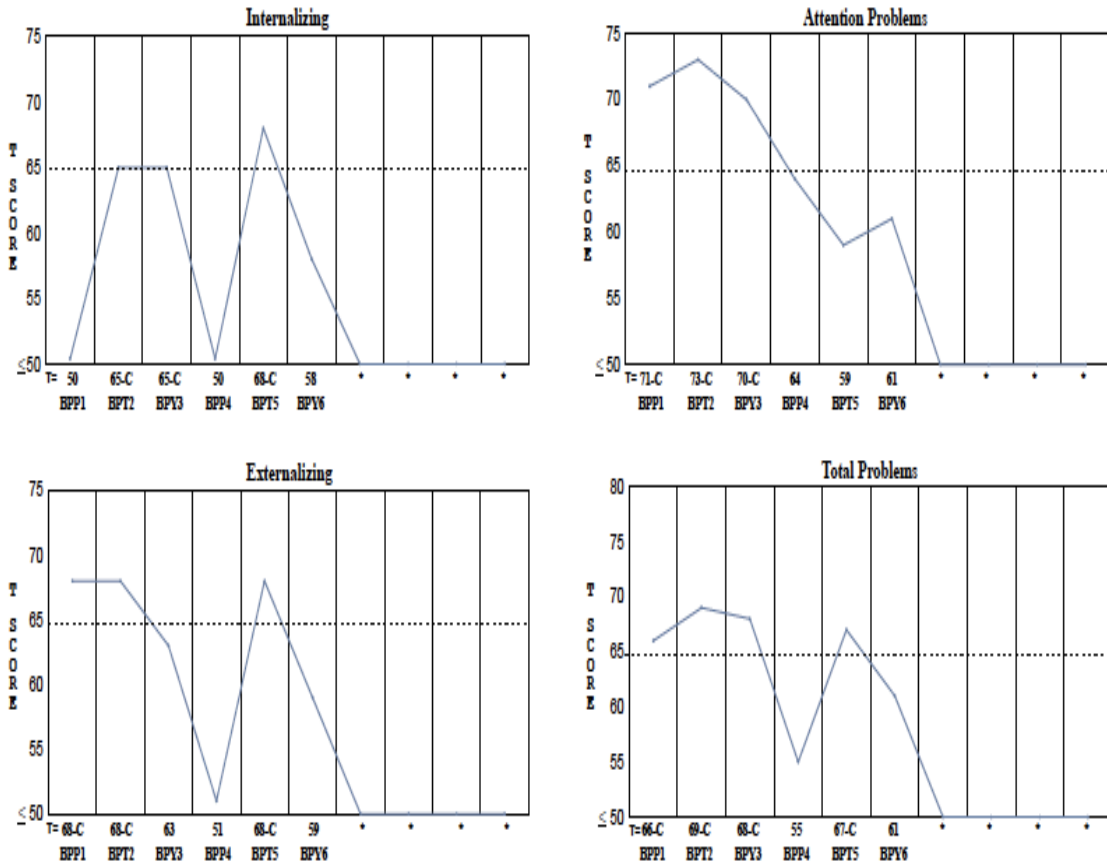


Figure 9 (b). BPM cross-informant trajectory graphs for Evan. BPY, BPP, and BPT = Brief Problem Youth, Parent, and Teacher (Achenbach et al., 2011). Copyright 2001 by T. Achenbach. Reprinted with permission.

Figure 10 (a) presents an analysis of Evan’s ORS scores using PND. Results indicated that 83% of his intervention scores were above his highest baseline ORS score. Thus, the intervention is considered *effective*.

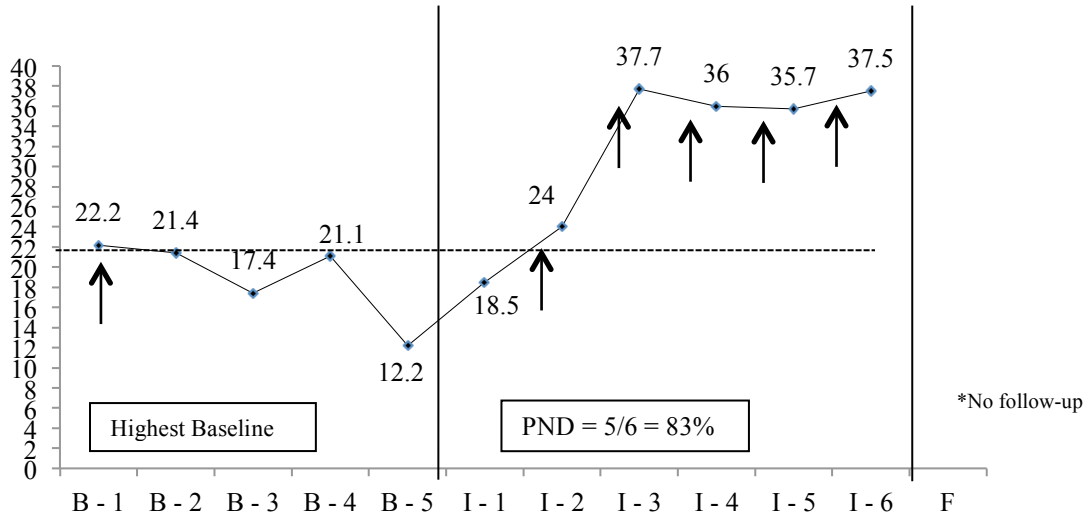


Figure 10 (a). Analysis of Evan’s ORS scores using PND.

Figure 10 (b) provides an analysis of Evan’s ORS scores using SMD. Results indicated a large ES ( $d = 3.06$ ).

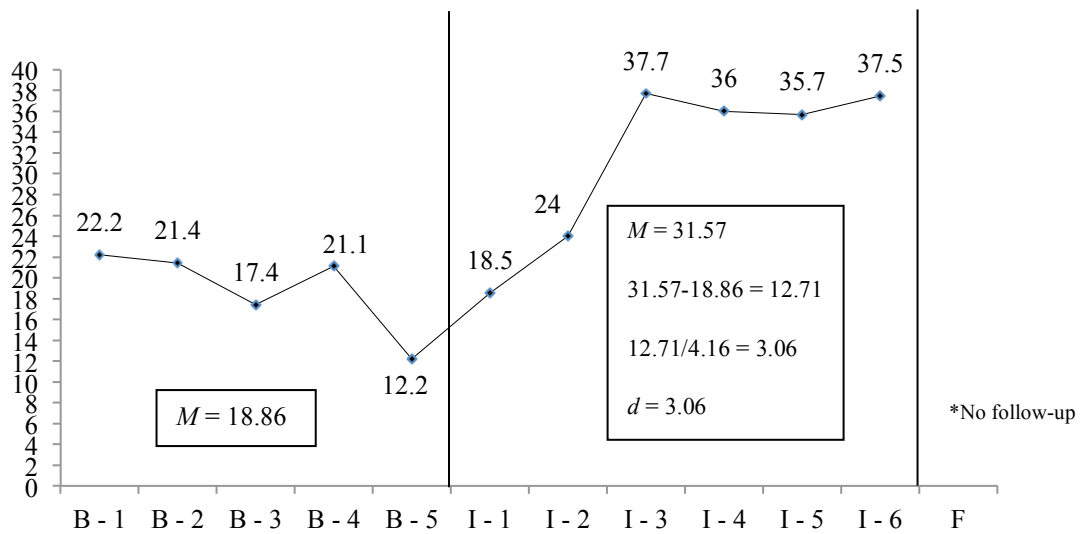


Figure 10 (b). Analysis of Evan’s ORS scores using SMD.

Figure 10 (c) reflects an analysis of Evan’s ORS scores using PEM. Results indicated that 83% of Evan’s intervention scores were above the baseline median ORS score (*Mdn* = 21.1).

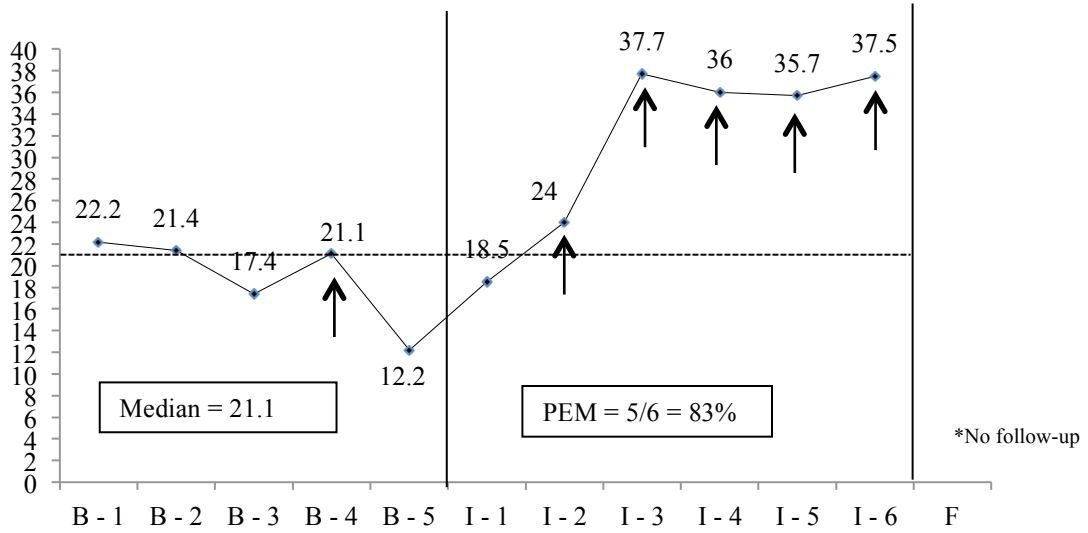


Figure 10 (c). Analysis of Evan’s ORS scores using PEM.



**Participant 6: Finn.** The four graphs in Figure 11 (a) represent the BPM cross-informant T-scores for each of the four domains at baseline-posttest, and at 6-week follow-up. Domains include: (a) Internalizing, (b) Attention Problems, (c) Externalizing, and (d) Total Problems. BPM-P indicated a decrease on Total Problems to below the clinical cutoff ( $T = \geq 65$ ) at posttest and at follow-up. Results indicated a decrease at posttest on BPM-T and BPM-Y; however, scores remained slightly about the clinical cutoff at posttest. Teacher ratings decreased to below the clinical cutoff at posttest. Finn's rating increased slightly at follow-up (i.e., one point).

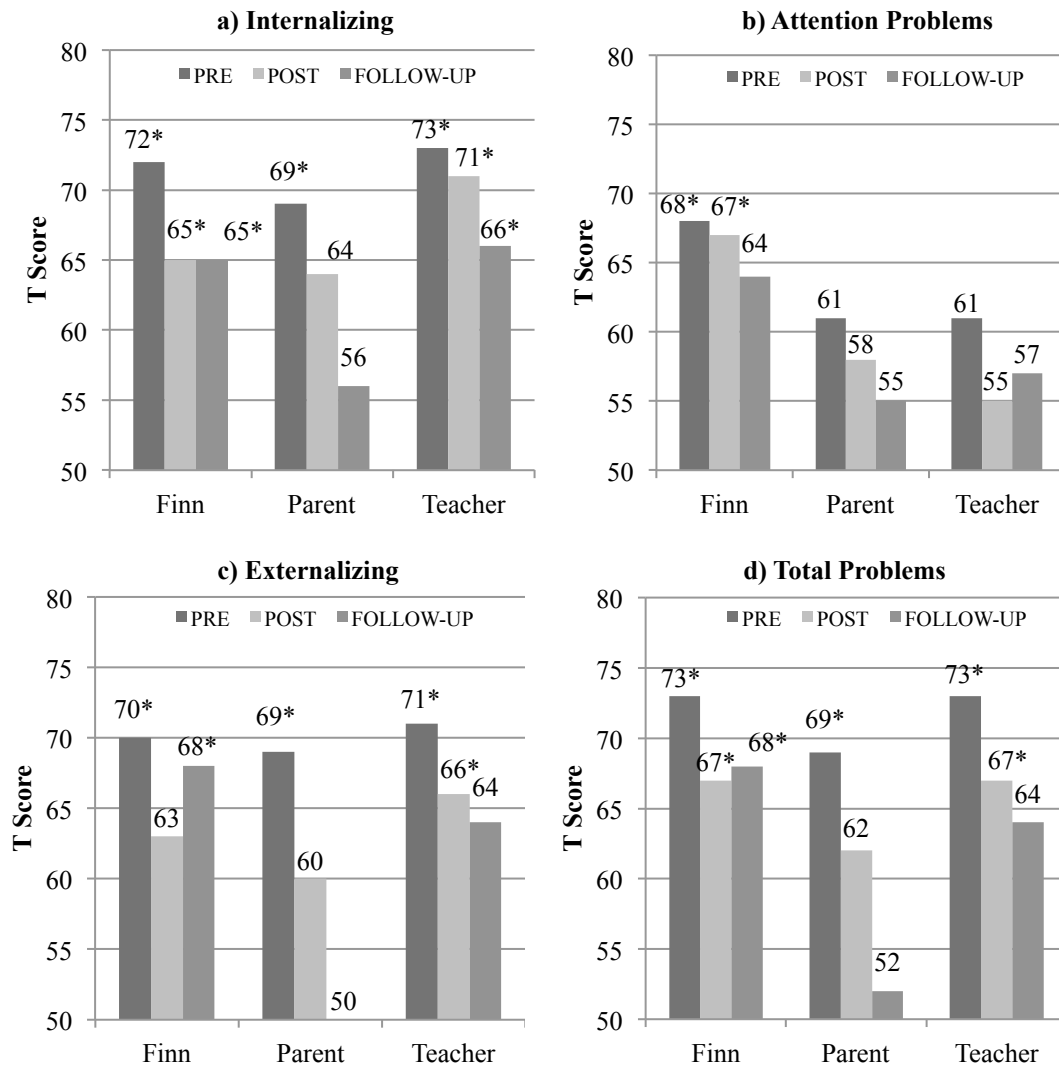


Figure 11 (a). BPM cross-informant bar graphs for Finn. \* $T = \geq 65$  (at or above clinical cutoff).

The BPM cross-informant trajectory graphs in Figure 11 (b) reflect a visual depiction of scores for each rater (i.e., parent, teacher, and youth) within each of the four domains for Finn across three time points (i.e., baseline, posttest, 6-week follow-up).

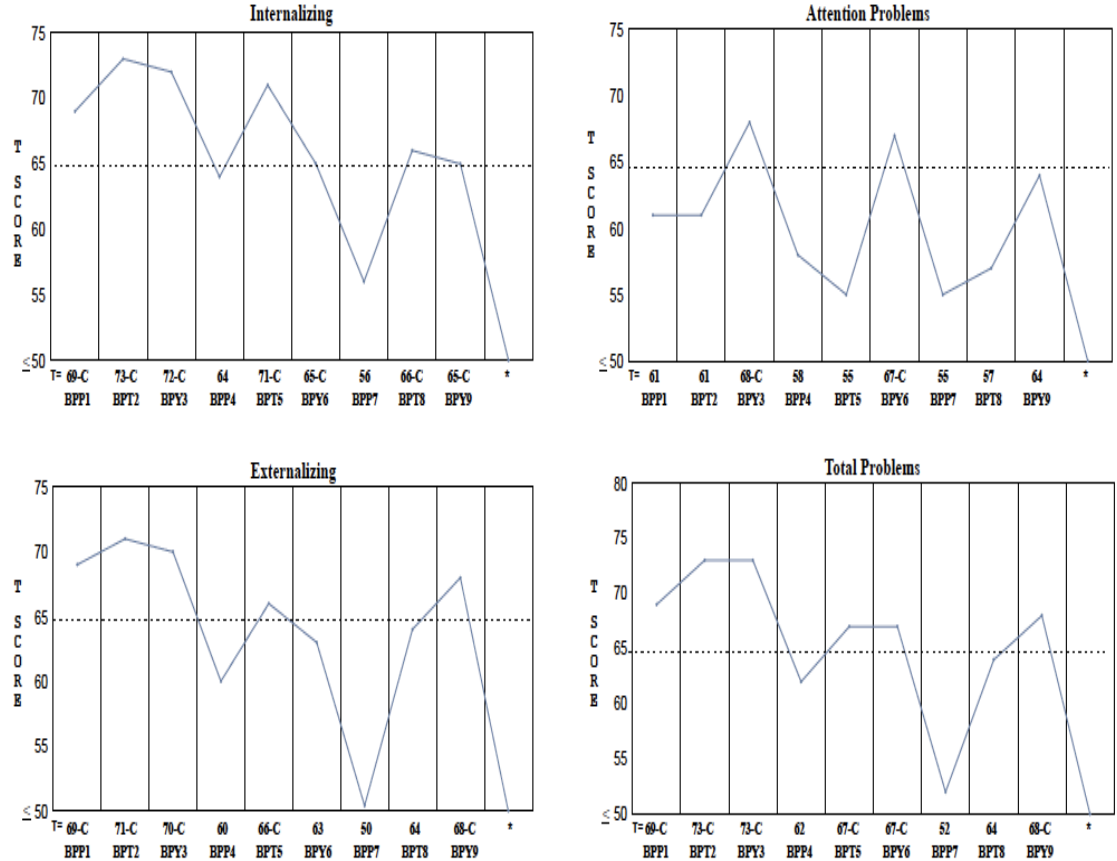


Figure 11 (b). BPM cross-informant trajectory graphs for Finn. BPY, BPP, and BPT = Brief Problem Youth, Parent, and Teacher (Achenbach et al., 2011). Copyright 2001 by T. Achenbach. Reprinted with permission.

Figure 12 (a) presents an analysis of Finn’s ORS scores using PND. Results indicated that 0% of his intervention scores were above his highest baseline ORS score. Thus, the intervention is considered *questionable* or *ineffective*.

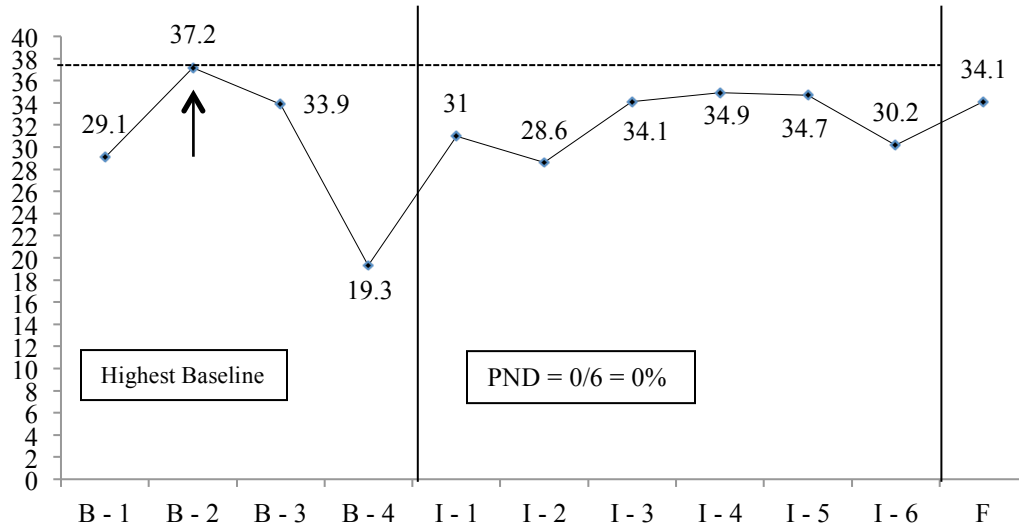


Figure 12 (a). Analysis of Finn’s ORS scores using PND.

Figure 12 (b) presents an analysis of Finn’s ORS scores using SMD. Results indicate a small ES ( $d = 0.30$ ).

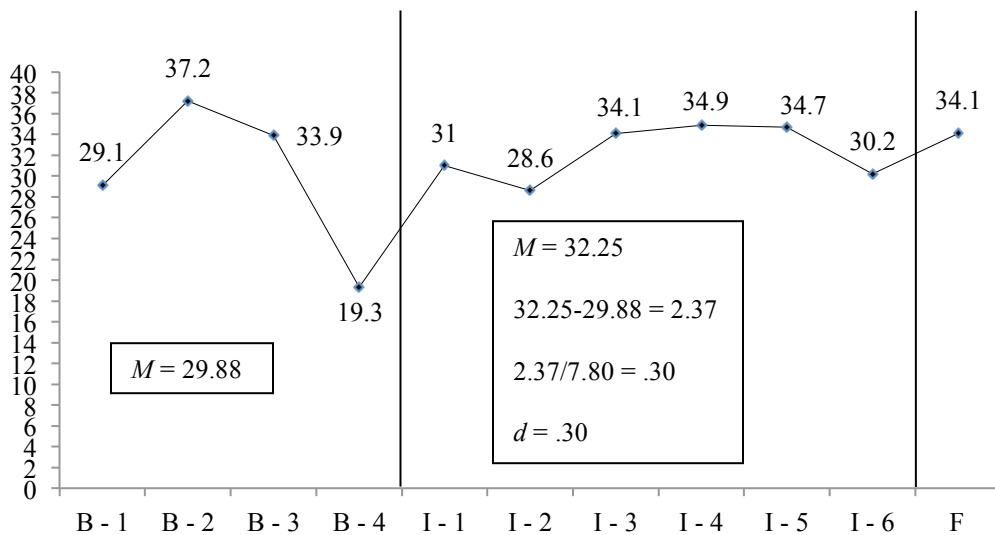


Figure 12 (b). Analysis of Finn’s ORS scores using SMD.

Figure 12 (c) presents an analysis of Finn's ORS scores using PEM. Results indicated that 50% of Finn's intervention scores were above the baseline median ORS score ( $Mdn = 31.5$ ).

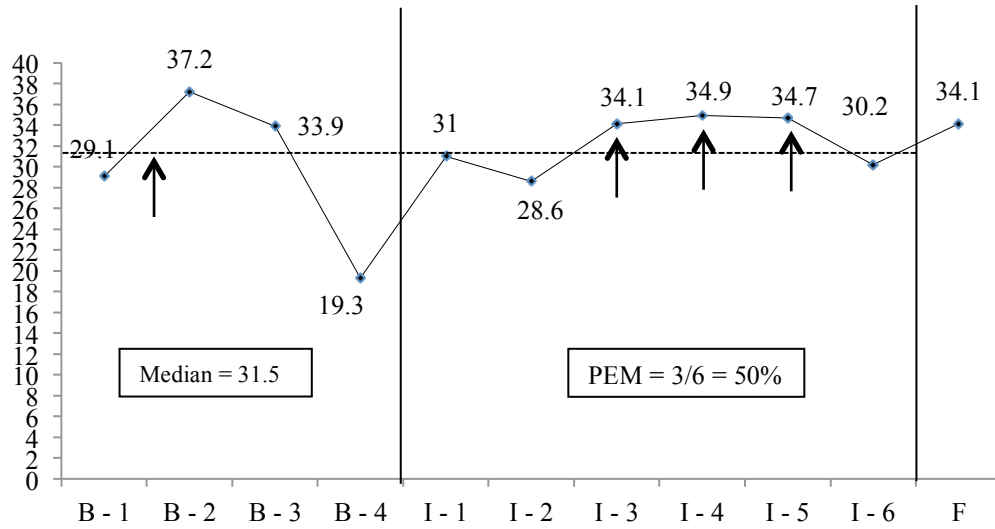


Figure 12 (c). Analysis of Finn's ORS scores using PEM.

## Student Responses to “Scaling Questions”

Table 5 presents a summary of student responses to “scaling questions” presented to them during the SFBT intervention sessions. Overall, results indicated an increase in ratings from the first session to the last session for all participants; however one student demonstrated fluctuations in his self-reported ratings, differing from the other students.

Table 5

### *Student Responses to “Scaling Questions”*

Student	Student-Identified Area of Concern	I - 1	I - 2	I - 3	I - 4	I - 5	I - 6	Change in Ratings
Andrew	Controlling anger	5.5	7	9.5	10	10	>10 (13)	+4.5
Bonnie	Focusing better in class	5	8	9	9	9.2	9.6	+4.6
Charlie	Controlling anger	4	6	9.5	9.7	9.9	10	+6
David	“Individually and socially”	4	7	8	9	10	10	+6
Evan	Controlling anger	1	8	8	9	10	10	+9
Finn	Controlling anger	4	5	7	7	7	5	+1

*Note.* At the beginning of each SFBT intervention, the clinician asked each student participant, “On a scale of 1-10, with 10 being completely being able to [behavior-related goal] (e.g., control anger, interact with peers, focus in class, etc.), and 1 being not at all able to [behavior-related goal] (e.g., control anger, interact with peers, focus in class, etc.), where do you feel like you are today?” The clinician then asked follow-up questions pertaining to the student’s rationale for the rating.

## Parent-Reported Concerns

Table 6 presents a summary of parent-reported concerns and severity ratings. Overall, results indicated a decrease in severity ratings from baseline to posttest for all parent raters.

Table 6

*Parent-Reported Concerns and Severity Ratings (Baseline to Posttest)*

Student	P	Primary Concern	Secondary Concern	Primary Concern Rating - Baseline	Secondary Concern Rating - Baseline	Primary Concern Rating - Posttest	Secondary Concern Rating - Posttest	Baseline - Posttest Change
Andrew	1	Anger	Verbal impulsivity ("Talking back")	MOD	SEV	MLD	MOD	<b>Decrease (Both)</b>
Bonnie	2	Truancy ("skips school")		MOD		MLD		<b>Decrease</b>
Charlie	3	Anger	Defiance ("Doesn't like to be told 'no'")	MOD	SEV	MLD	MOD	<b>Decrease (Both)</b>
David	4	Social functioning ("interactions in large groups")		SEV		MOD		<b>Decrease</b>
Evan	5	Anger		SEV		MOD		<b>Decrease</b>
Finn	6	Coping skills ("Learning how to ignore other kids")	Anger	SEV	SEV	MOD	MOD	<b>Decrease (Both)</b>

*Note.* At baseline, each parent (P) identified and rated a specific area(s) of concern regarding the child's behavior. Parents also completed ratings at posttest. A Likert scale was utilized to assess baseline-posttest behavioral change (i.e., MLD = Mild, MOD = Moderate, SEV = Severe, and EXS = Extremely Severe).

## Teacher-Reported Concerns

Table 7 presents a summary of teacher-reported concerns and severity ratings.

Overall, results indicated either a decrease or no change in severity ratings from baseline to posttest for all raters.

Table 7

*Teacher-Reported Concerns and Severity Ratings (Baseline to Posttest)*

Student	T	Primary Concern (#1)	Secondary Concern (#2)	Tertiary Concern (#3)	Baseline Severity Level of #1	Baseline Severity Level of #2	Baseline Severity Level of #3	Posttest Severity Level of #1	Posttest Severity Level of #2	Posttest Severity Level of #3	Baseline - Posttest Change
Andrew	1	Anger	Lack of self-control		MOD	EXS		MOD	MOD		No change (1); <b>Decrease (2)</b>
Bonnie	2	Defiance			MOD			MOD			No change
Charlie	3	Work avoidance	Bullying	Anger	EXS	MOD	SEV	MLD	MLD	SEV	<b>Decrease (1; 2); No change (3)</b>
David	4	Withdrawn			SEV			MLD			<b>Decrease</b>
Evan	5	Academics	On-task behaviors		SEV	SEV		MOD	MOD		<b>Decrease (Both)</b>
Finn	6	Argues	Verbal aggression		SEV	SEV		MLD	MOD		<b>Decrease (Both)</b>

*Notes.* At baseline, a teacher (T) identified and rated a specific area(s) of concern regarding the student's behavior. Teachers also completed ratings at posttest. A Likert scale was utilized to assess baseline-posttest behavioral change (i.e., MLD = Mild, MOD = Moderate, SEV = Severe, and EXS = Extremely Severe). Two teachers rated more than one student.

## Therapeutic Alliance Analysis

In this section, tertiary aims and research questions are addressed for each of the six participants (i.e., 3a, 3b, and 3c). Table 8 presents the mean ORS score of baseline data, the ORS mean score of the 6-session SFBT intervention, change in ORS scores from baseline-posttest, and the SRS mean score of the 6-session SFBT intervention. Results indicated clinically significant and reliable change in outcomes for four out of the six participants. SRS ratings indicated scores of above 36 for all student participants. This may indicate that a good working alliance was demonstrated between the clinician and student over the course of the intervention.

Table 8

### *Mean ORS from Baseline to Posttest and Mean SRS Scores for Student Participants*

Student Participant	Baseline ORS Mean ( <i>M</i> )	Intervention		SRS Mean ( <i>M</i> )
		ORS Mean ( <i>M</i> )	Change	
Andrew	24.3	33.6	9.3 <sup>a,b</sup>	37.4
Bonnie	29.27	34.47	5.2	39.55
Charlie	22.7	33.05	10.35 <sup>a,b</sup>	37.32
David	25.67	33.42	7.75 <sup>a,b</sup>	37.77
Evan	18.86	31.57	12.71 <sup>a,b</sup>	37.9
Finn	29.88	32.25	2.37	38.53

*Notes.* ORS = Outcome Rating Scale (Miller & Duncan, 2000). The ORS was completed during the multiple baseline (baseline) phases and at the beginning of each of the six SFBT intervention sessions. Students were randomized to one of three baseline sessions; thus, the ORS means at baseline indicated scores from three, four, or five baseline sessions. The SRS was completed at the end of each SFBT intervention.

<sup>a</sup>Clinically significant change

<sup>b</sup>Reliable change



Table 9 presents T-scores on the BPM-Y from baseline to posttest and the overall SRS mean score of the 6-session SFBT intervention. Results indicated that four students presented with BPM-Y T-scores above the clinical cutoff of  $\geq 65$  at baseline, and two students presented with BPM-Y T-scores slightly below the clinical cutoff at baseline. At posttest, results indicate that all BPM-Y T-scores decreased; however, one of the six participants maintained a BPM-Y Total Problems Domain score that was slightly above the clinical cutoff. SRS ratings indicated scores of above 36 for all student participants. This may indicate that a good working alliance was demonstrated between the clinician and student over the course of the intervention.

Table 9

*BPM-Y T-Scores and Mean SRS Scores for Student Participants from Baseline to Posttest*

Student Participant	Total Problems Domain Baseline T-Score (BPM-Y)	Total Problems Domain Posttest T-Score (BPM-Y)	SRS Mean ( <i>M</i> )
Andrew	65 <sup>a</sup>	53	37.4
Bonnie	63	55	39.55
Charlie	71 <sup>a</sup>	61	37.32
David	63	55	37.77
Evan	68 <sup>a</sup>	61	37.9
Finn	73 <sup>a</sup>	67 <sup>b</sup>	38.53

*Notes.* The Brief Problem Monitor, Youth Version (BPM-Y) was completed at baseline and posttest. Student participants also completed this measure at 6-week follow-up; however, it was not included due to the purpose of examining changes between baseline and posttest T-scores. The SRS was completed at the end of each SFBT intervention.

<sup>a</sup>At or above the clinical cutoff ( $T = \geq 65$ ) at baseline

<sup>b</sup>At or above the clinical cutoff ( $T = \geq 65$ ) at posttest

### Fidelity Evaluation Analysis

In this section, additional aims and research questions are addressed (i.e., 4a and 4b). Table 10 presents a summary of fidelity evaluation scores for each of the outside raters. Overall, results indicated mean adherence percentages of 94.32% and 91.40% for each of the evaluators. This may suggest adherence to SFBT and provide support for fidelity in the clinician’s implementation of the intervention. Results also indicated consistency between evaluators’ ratings.

Table 10

#### *Fidelity Evaluation Results*

Randomly Assigned Session	Evaluator A		Evaluator B		
	Rating (Total=91)	SFBT Adherence Percentage	Randomly Assigned Session	Rating (Total=91)	SFBT Adherence Percentage
1	88	96.7%	13	87	95.6%
2	83	91.2%	14	84	92.3%
3	89	97.8%	15	82	90.1%
4	88	96.7%	16	78	85.7%
5	87	95.6%	17	73	80.2%
6	86	94.5%	18	75	82.4%
7	85	93.4%	19	85	93.4%
8	85	93.4%	20	89	97.8%
9	86	94.5%	21	84	92.3%
10	81	89%	22	91	100%
11	83	91.2%	23	90	98.9%
12	89	97.8%	24	80	87.9%
<b>Mean (M)</b>	<b>M=85.83</b>	<b>M=94.32%</b>		<b>M=83.17</b>	<b>M=91.40%</b>

*Notes.* All of the intervention sessions were audiotaped. Each evaluator completed the fidelity measure following a review of 12 randomly assigned intervention sessions.

Sessions three, four, five, and six were reviewed for each of the student participants.

## Summary of Findings

Though initial parental concerns varied slightly, many reflected oppositional and conduct-related problems (e.g., anger, defiance). Other concerns included truancy and peer-related difficulties. In regard to severity level of these concerns, parents rated these areas in either the *moderate* or *severe* range at baseline. Teacher-reported concerns also reflected variability in type and in severity level. Concerns included oppositional and conduct-related problems (e.g., anger, defiance, bullying, verbal aggression), academic difficulties, internalizing issues (e.g., withdrawal, work avoidance), and attention problems. In regard to severity level of these concerns, teachers rated these areas in either the *moderate*, *severe*, or *extremely severe* range at baseline. At posttest, results indicated a decrease in severity ratings for all parent raters. In regard to teacher-reported areas of concern and severity ratings, results indicated either a decrease in or maintenance of severity ratings from baseline-posttest for all teachers.

During the SFBT intervention, student participants rated their area of concern via a “scaling question” (i.e., 1 = “not at all able to [behavior-related goal]” and 10 = “completely able to [behavior-related goal]”). Overall, based on their self-reported ratings during the last session, results indicated that five out of six students met (or exceeded) their goals. For Andrew, whose goal pertained to anger management, his rating increased from “5.5” to “greater than 10 (13)”. For Bonnie, whose goal addressed being able to focus better in class, her rating increased from “5” to “9.6”. For Charlie, whose goal related to anger management, his rating increased from “4” to “10.” For David, whose goal pertained to intrapersonal wellness and peer relationships, his rating also increased from “4” to “10.” For Evan, whose goal addressed anger management,

his goal increased from “1” to “10.” Finn’s self-reported ratings fluctuated over the course of the intervention and indicated variable.

**Overall treatment outcomes.** Preliminary results indicated that four out of six students exhibited reliable change. As discussed in Duncan (2014), a reliable change is reflected in an increase of six points or greater in the mean ORS score at posttest. Four out of six students also demonstrated clinically significant change at posttest. For adolescents, clinical significance is evidenced in a pre-ORS mean score of  $<28$ . The clinical cutoff on the ORS varies and depends on the age of the client (Duncan, 2014).

**BPM analyses.** For Andrew, outcome ratings on the Total Problems Domain on the BPM-T and BPM-Y indicated a decrease to below the clinical cutoff ( $T = \geq 65$ ) from baseline to posttest. Parent report indicated a decrease from baseline to posttest; however, this score remained slightly above the clinical cutoff at posttest.

For Bonnie, outcome ratings on the Total Problems domain indicated a decrease to below the clinical cutoff ( $T = \geq 65$ ) from baseline to posttest for all raters. Ratings maintained and or decreased at 6-week follow-up.

For Charlie, outcome ratings on the Total Problems domain indicated a decrease in ratings to below the clinical cutoff ( $T = \geq 65$ ) from baseline to posttest for Charlie and his mother. Teacher ratings indicated a posttest score at the clinical cutoff. All ratings decreased even more at 6-week follow-up.

For David, outcome ratings on the Total Problems domain on the BPM-Y, BPM-P, and BPM-T indicated a decrease to below the clinical cutoff ( $T = \geq 65$ ) from baseline to posttest. All ratings maintained or decreased at 6-week follow-up.

For Evan, outcome ratings on the Total Problems domain indicated a decrease in ratings to below the clinical cutoff ( $T = \geq 65$ ) from baseline-posttest for Evan and his parent. Teacher report indicated a decrease from baseline-posttest; however, her posttest score remained slightly above the clinical cutoff.

For Finn, outcome ratings on the Total Problems Domain on the BPM-P indicated a decrease to below the clinical cutoff ( $T = \geq 65$ ) from baseline to posttest. Ratings on the BPM-Y and BPM-T Total Problems Domain indicated a decrease from baseline to posttest. Posttest ratings on the BPM-Y and BPM-T remained slightly above the clinical cutoff. At follow-up, Finn's rating on the BPM-Y Total Problems Domain increased; BPM-P and BPM-T ratings decreased.

**ORS analyses.** For Andrew, percentage of non-overlapping data (PND) analysis indicated that 83% of his intervention scores were above his highest baseline ORS score. Based on this percentage, the SFBT intervention was considered *effective*. Andrew's ORS scores using standard mean difference (SMD) indicated a large ES ( $d = 3.96$ ). Analysis using percentage exceeding the mean (PEM) indicated that 100% of Andrew's intervention ORS scores were above the baseline median ORS score ( $Mdn = 25$ ).

For Bonnie, PND analysis indicated that 100% of her intervention scores were above her highest baseline ORS score. Based on this percentage, the SFBT intervention was considered *very effective*. Bonnie's ORS scores using SMD indicated a large ES ( $d = 6.82$ ). Analysis using PEM indicated that 100% of Bonnie's intervention scores were above the baseline median ORS score ( $Mdn = 29.6$ ).

For Charlie, PND analysis indicated that 100% of his intervention scores were above his highest baseline ORS score. Based on this percentage, the SFBT intervention

is considered *very effective*. Charlie's ORS scores using SMD indicated a large ES ( $d = 2.92$ ). Analysis using PEM indicated that 100% of Charlie's intervention scores were above the baseline median ORS score ( $Mdn = 23.1$ ).

For David, PND analysis indicated that 83% of his intervention scores were above his highest baseline ORS score. Based on this percentage, the SFBT intervention is considered *effective*. David's ORS scores using SMD indicated a large ES ( $d = 8.07$ ). Analysis using PEM indicated that 83% of David's intervention scores were above the baseline median ORS score ( $Mdn = 25.5$ ).

For Evan, PND analysis indicated that 83% of his intervention scores were above his highest baseline ORS score. Based on this percentage, the SFBT intervention is considered *effective*. Evan's ORS scores using SMD indicated a large ES ( $d = 3.06$ ). Analysis using PEM indicated that 83% of Evan's intervention scores were above the baseline median ORS score ( $Mdn = 21.1$ ).

For Finn, PND analysis indicated that 0% of his intervention scores were above his highest baseline ORS score. Based on this percentage, the SFBT intervention is considered *questionable* or *ineffective*. Finn's scores using SMD indicated a small ES ( $d = .30$ ). Analysis using PEM indicated that 50% of Finn's intervention scores were above the baseline median ORS score ( $Mdn = 31.5$ ).

**Therapeutic alliance data.** Results indicated SRS ratings of above 36 for all student participants. This may suggest that a good working alliance was demonstrated between the clinician and each student participant over the course of the SFBT intervention.

**Fidelity evaluation data.** Results indicated mean adherence percentages of 94.32% and 91.40% based on ratings from outside evaluators. This may suggest adherence to SFBT and provide support for fidelity in the clinician's implementation of the intervention. Results also indicated consistency between evaluators' ratings.

## Chapter Four: Discussion

### Summary of the Study

The purpose of this study was to determine the effectiveness of school-based SFBT with at-risk youth in an alternative school environment. Additionally, the researcher sought to evaluate the potential relationship between therapeutic alliance and treatment outcomes and adherence to SFBT through the use of fidelity monitoring. In regard to specific research questions identified in this study, a primary aim was to determine the level of change in outcome ratings from baseline to posttest and to assess if this change was maintained at 6-week follow-up. A secondary aim was to evaluate if the level of change was consistent between the different outcome measures utilized. A tertiary aim was to determine the presence of therapeutic alliance and if there was a relationship between therapeutic alliance ratings and student-reported behavior ratings. Additional aims focused on assessing if the researcher demonstrated adherence to SFBT via fidelity ratings from outside evaluators, as well as if consistency was evidenced between their ratings.

### Direct Findings

**Primary aim.** The primary aim of this study was to determine the level of change in treatment outcomes from baseline to posttest across six adolescent case studies. In addition, if change was demonstrated at posttest, the researcher sought to determine if it was maintained at 6-week follow-up. The researcher anticipated that student-reported ratings on the ORS would reflect clinically significant change based on an ORS baseline score of <28 (clinical cutoff for adolescents) for all student participants. The researcher also assessed reliable change via the reliable change index (RCI). According to Duncan, “The RCI indicates change that is greater than change, error, or maturation of the client.



The RCI on the ORS is 6 points.” (p.72). This change is evidenced if there is a 6-point increase between baseline and posttest mean scores. The researcher also expected that student-reported, parent, and teacher ratings on the BPM would decrease from baseline to post-intervention and maintain these ratings at 6-week follow-up.

**Findings.** Preliminary results on the ORS indicated that four out of six students exhibited reliable change, and four out of the six students demonstrated clinically significant change. Results also indicated a decrease from baseline to posttest in total problem behavior ratings across all informants on the BPM. Clinically significant change on the BPM Total Problems Domain was demonstrated from baseline to posttest for the following raters: Andrew and his teacher, Bonnie’s parent, Charlie and his parent, Evan and his parent, and Finn’s parent. Scores decreased, but still remained at or above the clinical cutoff on this measure and domain, for the following raters: Andrew’s parent, Charlie’s teacher, Evan’s teacher, and Finn and his teacher. Scores decreased and were also below the clinical cutoff at baseline for the following raters: Bonnie and her teacher, and David, his parent, and his teacher. Follow-up data were collected for four out of six students, and results suggested that this decrease in ratings was maintained or decreased further across all raters for three out of the four student participants. Overall, these results indicate that the majority of students experienced both reliable and clinically significant change. Thus, it appears that the SFBT intervention may be a useful framework in the management and reduction of problem behaviors in at-risk youth within an alternative school environment.

**Secondary aim.** The secondary aim of this study was to determine if there was a relationship between change in ORS scores and change in BPM ratings. The researcher

expected that the results suggest a relationship between changes in student-reported, parent, and teacher ratings on the BPM and changes in student-reported scores on the ORS. Specifically, the researcher anticipated a decrease in negative behavior ratings on the BPM among all raters and an increase in student-reported scores on the ORS.

**Findings.** Results indicated that scores on the ORS increased for all student participants; however, clinically significant and reliable change was demonstrated for four out of the six participants. Mean ORS scores at posttest increased from 7.75 to 12.71 points for these four students. Mean ORS scores at posttest increased 2.37 and 5.2 points for the other two student participants. On the BPM Total Problems Domain at posttest, scores decreased for all parent, teacher, and student raters. Results on this measure and domain indicated that for three students, clinically significant change was demonstrated for two out of three raters. Further, for two other students, clinically significant change was indicated in scores for one out of three raters. One student obtained scores that were below the clinical cutoff at baseline for all raters. Overall, though ratings demonstrated variability in the level of clinically significant and reliable change, scores on both the ORS and on the BPM Total Problems Domain reflected a positive change in all students' emotional and behavioral functioning.

**Tertiary aim.** The tertiary aim of this study was to determine the presence of therapeutic alliance and if there was a relationship between therapeutic alliance ratings and student-reported behavior ratings. The researcher anticipated the results to indicate evidence in support of student-therapist alliance, as reflected in scores of 36 or higher on the SRS. It was also expected that results indicate a change in ORS scores and higher

ratings on the SRS. Further, the researcher expected higher ratings on the SRS and lower scores on the BPM from pre-intervention to post-intervention across all raters.

**Findings.** Results indicated that SRS ratings were above 36 for all student participants. Mean SRS scores ranged from 37.32 to 39.55. Scores on both the ORS and on the BPM Total Problems Domain indicated positive outcomes pertaining to students' level of functioning at posttest. As discussed, though level of clinical significant and reliable change varied between informant ratings at posttest, results suggested that students experienced gains in their emotional and behavioral functioning. Overall, results indicated that a good working alliance was demonstrated, and a positive change in outcomes was exhibited at posttest.

**Additional aims.** The present study also encompassed additional aims pertaining to fidelity monitoring. The researcher sought to determine if fidelity to SFBT was evidenced in the ratings of outside evaluators and if consistency was demonstrated between those ratings. The researcher anticipated that the results indicate adherence to SFBT, as reflected in total scores between 65-91 on the fidelity measure. The researcher also expected the fidelity ratings to reflect consistency between both evaluators.

**Findings.** Results indicated mean adherence percentages of 94.32% and 91.40% for each of the evaluators. This may suggest adherence to SFBT and provide support for fidelity in the clinician's implementation of the intervention. Results also indicated consistency between evaluators' ratings, which may further support that the examiner implemented the SFBT intervention as it was intended in the SFBT treatment manual and protocols that guided the researcher's SFBT sessions.

## **Contributions**

The methodology in the present study embodies a number of strengths. Results from this study may contribute to the literature on SFBT due to the limited research on the implementation of SFBT in an alternative school setting. The present study incorporated a rigorous research design, which was reflected in the inclusion of several outcome measurement tools, an alliance measure, and fidelity monitoring by two outside raters. Another major strength of this study was that it encompassed the use of numerous informants (i.e., parents, teachers, and self-reports). The utilization of a multiple-baseline design and the inclusion of numerous data collection points (i.e., baseline, beginning and end of the six intervention sessions, posttest, and 6-week follow-up) are other strengths indicated in this study.

## **Limitations**

Though the present study embodied a number of strengths, there are limitations and considerations that should be addressed. The methodological design of this study was single-subject, which research indicates has been applied in settings, such as schools, due to the potential relationship between the problems and more naturalistic environment and the individualized nature of the problem behaviors. However, a review of the related literature yields concerns relating to the external validity of single-subject treatment outcomes. The present study also lacked a control group, encompassed a small sample size, and utilized self-report data, which should be considered when interpreting the results. Further, only one therapist provided the treatment intervention, which may have impacted student outcomes. Another consideration is that this study was conducted in a setting wherein students were exposed to individual and group therapy services. This

exposure may have introduced the internal validity threat of multiple treatment interference.

### **Implications for Researchers**

A review of the related literature indicates some evidence in support of the relationship between the quality of the therapeutic alliance and treatment outcomes. According to Duncan (2014), clinicians should utilize a therapeutic alliance measure, such as the SRS, as a means to gain useful feedback from the client on their overall therapy experience. Duncan (2014) also identified that though there is criticism of the validity of the SRS in evaluating alliance (e.g., fear of hurting the therapist's feelings), it is essential to consider that,

if you are striving for feedback and not putting any value on positive scores- in fact quite the opposite- then social desirability and demand characteristics don't make much logical sense. In that case, the desire to please, to be socially appropriate, would lead to a demand for lower scores, not inflated ones."

(Duncan, 2014, p. 63).

An alliance measure may provide both the therapist and client with a guided framework to address the client's perceived relationship with the therapist. Ultimately, "...appreciation of any negative feedback is a powerful alliance builder...getting at what the client liked about the session can also be useful. Anything that helps a conversation about the alliance is good" (Duncan, 2014, pp. 64-65).

Research suggests that there are other potential moderator variables pertaining to both client (e.g., age, level of functioning, environmental challenges) and therapist characteristics that may impact outcomes; however, as highlighted by Schmidt and

Schimmelmann (2015), “moving beyond knowing *that* a treatment is effective to explaining *how* its effects occur should become another priority in psychotherapy research on children and adolescents” (p. 249). Overall, research yields inconclusive findings in regard to specific variables that may impact treatment outcomes in isolation of one another; however, the literature in this area provides evidence in support of a more subjective understanding of change predictors. Results necessitate further research on the impact of predictor variables on youth treatment outcomes.

A review of the related literature on SFBT indicates a need for more rigorous methodological designs with randomization of participants and fidelity and integrity monitoring. Randomization may be challenging within a school domain; however, it is anticipated that studies with this component may provide more substantive and generalizable results. Future research may also focus on including a much larger and more diverse sample size. Due to the infrequent inclusion of fidelity monitoring in SFBT studies and the importance of evaluating practitioner adherence, researchers should also include fidelity monitoring in their future research in this area.

Though there is a general treatment manual on SFBT developed by Bavelas et al. (2013), future research may focus on the design of a manual or protocol to use within the school environment. Schools are inherently different than other potential mental health domains, which may reflect a need for an individualized treatment manual or protocol that addresses the challenges faced by school-based mental health providers. In addition, it may be useful to determine the effectiveness of school-based SFBT at different tiers of intervention, as well as with different populations within those levels.

## **Implications for School-Based Practitioners**

As reflected in the school-based psychotherapy literature, schools may be an ideal environment to address mental health concerns in youth due to the potential relationship between academic and emotional and behavioral functioning. A review of the related research on school-based SFBT suggests that this therapy may be well suited to school contexts given its focus on intra- and interpersonal strengths, brief interventions, and measurable goals. Research in this area indicates the potential interconnectedness between academic and behavioral functioning and supports that school clinicians may be in a unique position to offer preventative and immediate interventions that address the impact of mental health concerns on academic success.

## **Conclusions**

Results from the present study indicated the potential benefit of SFBT with at-risk youth in an alternative school environment. This benefit was exhibited in parent, teacher, and self-report ratings, which reflected a decrease in problem areas and an increase in students' level of functioning within individual, interpersonal, and social domains.

A review of the child psychotherapy literature indicates that youth with emotional and/or behavioral concerns who are exposed to mental services may exhibit better outcomes than those who do not receive services and present with these concerns. Research suggests that, "as many as 1 in 10 children suffer from a mental, behavioral, or learning problem that interferes with their ability to function effectively in school or in the community" (Stoep et al., 2005, p. 213). This is a noteworthy consideration as school clinicians are capable of providing academic and emotional and behavioral interventions to a broad range of child and adolescent populations. Due to the proportion of youth with emotional health issues within this environment, it is suggested that schools should offer

preventative and immediate services in an attempt to address emotional distress as early as possible in these youth.

Future research in this area should focus on the effectiveness of various school-based psychotherapies on specific child and adolescent outcomes and on the expansion of youth psychotherapy studies within different practice domains and with a range of populations and mental health concerns. As identified by Mufson, Dorta, Olfson, Weissman, and Hoagwood (2004), “although effectiveness research poses numerous challenges, the identification of effective treatments that are feasible, acceptable, and capable of being implemented within communities is of paramount importance if children’s mental health outcomes are to be improved” (p. 259). Research on effectiveness of SFBT with children and adolescents indicates preliminary support for its use with youth experiencing externalizing and internalizing behaviors in school and within the home environment (Bond et al., 2013). Of note, it is imperative for future researchers to address the methodological issues evidenced in a number of SFBT studies (e.g., small sample size, lack of comparison groups, lack of fidelity and integrity monitoring) to further enhance the research on the utility of SFBT with children and adolescents.



## Appendix A

### Approval Letter from the Administrative Director/Director of Special Education

January 14, 2014

Dear University of Kentucky Institutional Review Board Committee Members,

This is a letter of support for the study that will be conducted by Martha C. Hinchey, M.S. in the spring of 2014 at the SCHOOL located in COUNTY, STATE. The specifics of Ms. Hinchey's study on the implementation of solution-focused brief therapy (SFBT) with at-risk youth in an alternative school environment have been reviewed by me, NAME, the Administrative Director/Director of Special Education in COUNTY, and appear very appropriate for the population at the SCHOOL. The students within this school are in great need of therapeutic services, and we welcome the opportunity for Ms. Hinchey to provide these services to the students at the SCHOOL. Please feel free to contact me regarding my approval of Ms. Hinchey's study. My email is: \_\_\_\_\_.

Sincerely,

NAME  
Administrative Director/Director of Special Education  
COUNTY Public Schools

### Approval Letter from the Principal of the Alternative School

January 14, 2014

Dear University of Kentucky Institutional Review Board Committee Members,

This is a letter of support for the study that will be conducted by Martha C. Hinchey, M.S. in the spring of 2014 at the SCHOOL located in COUNTY, STATE. The specifics of Ms. Hinchey's study on the implementation of solution-focused brief therapy (SFBT) with at-risk youth in an alternative school environment have been reviewed by me, NAME, the principal of the SCHOOL, and appear very appropriate for our population. Our students are in great need of therapeutic services, and we welcome the opportunity for Ms. Hinchey to provide these services to our students. Please feel free to contact me regarding my approval of Ms. Hinchey's study. My email is: \_\_\_\_\_.

Sincerely,

NAME  
Principal  
SCHOOL

## Appendix B

### Parent/Legal Guardian Consent to Allow Minor to Participate in a Research Study

#### THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT

##### WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You and your child are being invited to take part in a research study about the effectiveness of school-based mental health services (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. You are being invited to take part in this research study because you are the parent or legal guardian of a minor at X School in CITY, STATE. If you allow your child to volunteer to take part in this study, your child will be one of about 9 youth to do so. You will also be one of about 9 parents/legal guardians to participate.

##### WHO IS DOING THE STUDY?

The person in charge of this study is Martha C. Hinchey, M.S. (*Principal Investigator, PI*) from the University of Kentucky Department of School Psychology. Ms. Hinchey is a fourth year doctoral student in this department. She is being guided in this research by H. Thompson Prout, Ph.D. There may be other people on the research team assisting at different times during the study.

##### WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to determine the effectiveness of a school-based mental health (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. By doing this study, we hope to learn if this type of therapy is effective with this population.

##### ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

You may be excluded from this study if you are not the parent or legal guardian of a minor at X School in CITY, STATE.

##### WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research procedures will be conducted at X School in CITY, STATE. Your child will be asked to complete a series of brief assessments as well as participate in counseling sessions. At the beginning of the study, your child will complete a brief assessment between 3-5 times over the course of 2 and ½ weeks. This assessment takes around 3 minutes to complete. Your child will also be asked to complete another brief assessment 3 times over the course of the study (i.e., beginning, end, and 6 weeks following the end of the study) that takes around 5 minutes to complete. Your child will be asked to attend 6 counseling sessions lasting around 40 minutes over the course of a month and complete 2 brief assessments during each session that take around 3 minutes to fill out. The design of the study is multiple-baseline, which means that your child will receive the counseling intervention after an established set of baseline data points. Your child will be randomized to 1 of 3 groups, receiving the counseling intervention after 3, 4, or 5 data points have been collected. By signing this form, you are acknowledging that you are aware of this and understand that your child will not immediately receive the counseling intervention, but will after 1 to 2 weeks from the date that you and your child consent/assent to participating in the study.

##### WHAT WILL YOU BE ASKED TO DO?

You are being asked to give your consent to allow your child to participate in this study. Additionally you are being asked to give your consent to allow Ms. Hinchey to review your child's cumulative records, which are available at X School and contain forms completed at intake before your child was enrolled at X School (e.g., consent forms, developmental history form, general descriptive information about your child), and your child's academic performance thus far in school and to give your consent to allow Ms. Hinchey to interview one of your child's teachers regarding presenting concerns identified by him or her about your child and collect data (i.e., rating scales) from this teacher. Lastly, you are being asked to give your consent to allow Ms. Hinchey to audio-record each of the counseling sessions with your child.

##### WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

You may find some questions that we ask your child to be upsetting or stressful. Additionally, your child's level of concerns may increase over the course of the study. If your child's baseline scores are indicating a significant level of distress, as evidenced by significantly decreasing scores on the baseline rating scale, the researcher will discuss this with the student participant and determine the risks versus benefits of the researcher collecting more data points versus the student participating in immediate counseling services. If the student participant's ratings on the rating scales are decreasing over the course of the study, the researcher will discuss this with the student participant and review options with him or her (e.g., identify barriers, identify methods to overcome barriers, determine benefits vs. risks of continuing participation in the study and whether a referral is warranted, etc.). In addition to the risks listed above, your child may experience a previously unknown risk or side effect. If your child discusses suicidal ideation, homicidal ideation, self-harm, or abuse, the researcher will follow the policies and procedures in place at the school, as well as comply with local, federal, and state policies regarding confidentiality. The researcher will first assess the severity, intensity, and/or level of intent. If it appears that there is a significant and legitimate risk of harm the researcher will then: (1) discuss the next steps with the student; (2) contact her supervisor/principal; (3) contact you; (4) provide options for more intensive evaluation/services (e.g., X Facility; Y Facility).

##### WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that your child will get any benefit from taking part in this study. Your willingness to allow your child to take part, however, may, in the future, help society as a whole better understand this research topic.

**DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to allow your child to take part in the study, it should be because you really want to him or her to volunteer. Your child will not lose any benefits or rights he or she would normally have if you choose not to allow him or her to volunteer. Your child can stop at any time during the study and still keep the benefits and rights he or she had before volunteering.

**IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want your child to be in the study, there are no other choices except not to let him or her take part in the study.

**WHAT WILL IT COST YOU TO PARTICIPATE?**

There is no cost for allowing your child to participate in this study.

**WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?**

You or your child will not receive any rewards or payment for taking part in the study.

**WHO WILL SEE THE INFORMATION THAT YOU GIVE?**

Your information and your child's information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You and your child will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your and your child's name and other identifying information private. We will make every effort to prevent anyone who is not on the research team from knowing that you and your child gave us information, or what that information is. All information will be kept confidential in accordance with the University of Kentucky Office of Research Integrity's standards for collection and storage of hard copy and electronic data (2011). All data will be kept on a university owned password-protected computer in the researcher's locked office, with reported identifiable data (e.g., name of student, parent, or teacher) stored separately from data obtained in an encrypted password protected file. All consent/assent forms will be stored separately from all data obtained and all hard copy data (i.e., rating scales, assessments, notes from review of records, presenting concerns forms) will also be stored separately from identifying information in a locked filing cabinet within the researcher's locked office located at XXX Building, University of Kentucky, Lexington, KY 40536. The only person who will have access to the data/identifiable data is the researcher. All participants will be assigned a research record number that will be used on all ratings scales, assessments, forms, or notes utilized in the study. The research record number and identifying information will be stored separately from one another. We will keep private all research records that identify you and your child to the extent allowed by law. However, there are some circumstances in which we may have to show your and your child's information to other people. For example, the law may require us to show your and your child's information to a court or to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you and your child to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky.

**CAN YOUR TAKING PART IN THE STUDY END EARLY?**

If you decide to participate and to allow your child to take part in the study you still have the right to decide at any time that you and your child no longer want to continue. You and your child will not be treated differently if you and your child decide to stop taking part in the study. The individuals conducting the study may need to withdraw you and your child from the study. This may occur if you and your child are not able to follow the directions they give you and your child or if they find that your and your child's being in the study is more risk than benefit to you and your child.

**THE STUDY THAT MIGHT AFFECT YOUR DECISION TO PARTICIPATE?**

If the researcher learns of new information in regards to this study, and it might change your willingness to allow your child to stay in this study, the information will be provided to you. You may be asked to sign a new informed consent form if the information is provided to you after you have allowed your child to join the study.

**WHAT ELSE DO YOU NEED TO KNOW?**

There is a possibility that the data collected from you and your child may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you and your child unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

**WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?**

Before you decide whether to accept this invitation to allow your child to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Martha C. Hinchey, M.S. at [email@address.com](mailto:email@address.com), or the faculty supervisor H. Thompson Prout, Ph.D. at [email@address.com](mailto:email@address.com). If you have any questions about your or your child's rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

_____ Signature of person permitting his/her child to take part in the study	_____ Date
_____ Printed name of person permitting his/her child to take part in the study	_____ Date
_____ Name of minor authorized to participate in the study	_____ Date
_____ Name of (authorized) person obtaining informed consent	_____ Date

## Appendix C

### Consent to Participate in a Research Study (if 18)

#### THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT

##### WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about the effectiveness of school-based mental health services (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. You are being invited to take part in this research study because you are a student at X School in CITY, STATE and are 18-years-old. If you volunteer to take part in this study, you will be one of about 9 individuals to do so.

##### WHO IS DOING THE STUDY?

The person in charge of this study is Martha C. Hinchey, M.S. (*Principal Investigator, PI*) from the University of Kentucky Department of School Psychology. Ms. Hinchey is a fourth year doctoral student in this department. She is being guided in this research by H. Thompson Prout, Ph.D. There may be other people on the research team assisting at different times during the study.

##### WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to determine the effectiveness of a school-based mental health (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. By doing this study, we hope to learn if this type of therapy is effective with this population.

##### ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

You may be excluded from this study if you are not currently enrolled at X School in CITY, STATE.

##### WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The research procedures will be conducted at X School in CITY, STATE. You will be asked to complete a series of brief assessments as well as participate in counseling sessions. At the beginning of the study, you will complete a brief assessment between 3-5 times over the course of 2 and ½ weeks. This assessment takes around 3 minutes to complete. You will also be asked to complete another brief assessment 3 times over the course of the study (i.e., beginning, end, and 6 weeks following the end of the study) that takes around 5 minutes to complete. You will be asked to attend 6 counseling sessions lasting around 40 minutes over the course of a month and complete 2 brief assessments during each session that take around 3 minutes to fill out.

##### WHAT WILL YOU BE ASKED TO DO?

Initially, you will complete a consent form and developmental history form. Questions on the developmental history form may include description information (e.g., age, grade, gender, race, and ethnicity) about you, previously received or present counseling services received by you, and previous and/or current diagnoses. As previously discussed, at the beginning of the study, you will complete a brief assessment between 3-5 times over the course of 2 and ½ weeks. You will also be asked to complete another brief assessment 3 times over the course of the study (i.e., beginning, end, and 6 weeks following the end of the study). You will be asked to attend 6 counseling sessions twice per week over the course of a month and complete 2 brief assessments during each session. Additionally you are being asked to give your consent to allow Ms. Hinchey to review your cumulative records, which are available at X School and contain forms your parent/legal guardian completed at intake before you were enrolled at X School (e.g., consent forms, developmental history form, general descriptive information about you) and your academic performance thus far in school and to give your consent to allow Ms. Hinchey to interview one of your teachers regarding presenting concerns identified by him or her about you and collect data (i.e., rating scales) from this teacher. You are also being asked to give your consent to allow Ms. Hinchey to interview one of your parents/legal guardians, if you are currently living with him or her, regarding presenting concerns identified by him or her about you and collect data (i.e., rating scales) from this individual. Lastly, you are being asked to give your consent to allow Ms. Hinchey to audio-record each of the counseling sessions with you.

##### WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

You may find some questions that we ask you to be upsetting or stressful. Additionally, your level of concerns may increase over the course of the study. If your baseline scores are indicating a significant level of distress, as evidenced by significantly decreasing scores on the baseline rating scale, the researcher will discuss this with you and determine the risks versus benefits of the researcher collecting more data points versus you participating in immediate counseling services. If your ratings on the rating scales are decreasing over the course of the study, the researcher will discuss this with you and review options (e.g., identify barriers, identify methods to overcome barriers, determine benefits vs. risks of continuing participation in the study and whether a referral is warranted, etc.). In addition to the risks listed above, you may experience a previously unknown risk or side effect. If you discuss suicidal ideation, homicidal ideation, self-harm, or abuse, the researcher will follow the policies and procedures in place at the school, as well as comply with local, federal, and state policies regarding confidentiality. The researcher will first assess the severity, intensity, and/or level of intent. If it appears that there is a significant and legitimate risk of harm the researcher will then: (1) discuss the next steps with the student; (2) contact her supervisor/principal; (3) provide options for more intensive evaluation/services (e.g., X Facility; Y Facility).

##### WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will get any benefit from taking part in this study. Your willingness to take part, however, may, in the future, help society as a whole better understand this research topic.



## Appendix D

### Parent/Legal Guardian Consent to Participate in a Research Study

#### **THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT**

##### **WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?**

You are being invited to take part in a research study about the effectiveness of school-based mental health services (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. You are being invited to take part in this research study because you are the parent or legal guardian of a student already enrolled in the study. If you volunteer to take part in this study, you will be one of about 9 people to do so.

##### **WHO IS DOING THE STUDY?**

The person in charge of this study is Martha C. Hinchey, M.S. (*Principal Investigator, PI*) from the University of Kentucky Department of School Psychology. Ms. Hinchey is a fourth year doctoral student in this department. She is being guided in this research by H. Thompson Prout, Ph.D. There may be other people on the research team assisting at different times during the study.

##### **WHAT IS THE PURPOSE OF THIS STUDY?**

The purpose of this study is to determine the effectiveness of a school-based mental health (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. By doing this study, we hope to learn if this type of therapy is effective with this population.

##### **ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?**

You may be excluded from this study if you are not the parent or legal guardian of the student already enrolled in the study.

##### **WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?**

The research procedures will be conducted at X School in CITY, STATE. You will need to come to X School 1 time during the study. This visit will take about 30 minutes. The total amount of time you will be asked to volunteer for this study is 45 minutes over the next 3 months.

##### **WHAT WILL YOU BE ASKED TO DO?**

When you come to X School, you will complete a consent form, developmental history form on your child, and a brief assessment on your child's behavior. Questions on the developmental history form may include description information (e.g., age, grade, gender, race, and ethnicity) about your child, previously received or present counseling services received by your child, and your child's previous and/or current diagnoses. You will also be asked to complete the same brief assessment on your child's behavior at the end of the study and 6 weeks following the end of the study. This assessment takes around 5 minutes to complete.

##### **WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

You may find some questions we ask you to be upsetting or stressful. In addition to the risks listed above, you may experience a previously unknown risk or side effect.

##### **WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?**

There is no guarantee that you will get any benefit from taking part in this study. Your willingness to take part, however, may, in the future, help society as a whole better understand this research topic.

##### **DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

##### **IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want to be in the study, there are no other choices except not to take part in the study.

##### **WHAT WILL IT COST YOU TO PARTICIPATE?**

You may have to pay for the cost of getting to the study site.

**WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?**

You will not receive any rewards or payment for taking part in the study.

**WHO WILL SEE THE INFORMATION THAT YOU GIVE?**

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you and your child gave us information, or what that information is. All information will be kept confidential in accordance with the University of Kentucky Office of Research Integrity’s standards for collection and storage of hard copy and electronic data (2011). All data will be kept on a university owned password-protected computer in the researcher’s locked office, with reported identifiable data (e.g., name of student, parent, or teacher) stored separately from data obtained in an encrypted password protected file. All consent/assent forms will be stored separately from all data obtained and all hard copy data (i.e., rating scales, assessments, notes from review of records, presenting concerns forms) will also be stored separately from identifying information in a locked filing cabinet within the researcher’s locked office located at XXX Building, University of Kentucky, Lexington, KY 40536. The only person who will have access to the data/identifiable data is the researcher. All participants will be assigned a research record number that will be used on all ratings scales, assessments, forms, or notes utilized in the study. The research record number and identifying information will be stored separately from one another.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky.

**CAN YOUR TAKING PART IN THE STUDY END EARLY?**

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study. The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you or if they find that your being in the study is more risk than benefit to you.

**WHAT IF NEW INFORMATION IS LEARNED DURING THE STUDY THAT MIGHT AFFECT YOUR DECISION TO PARTICIPATE?**

If the researcher learns of new information in regards to this study, and it might change your willingness to stay in this study, the information will be provided to you. You may be asked to sign a new informed consent form if the information is provided to you after you have joined the study.

**WHAT ELSE DO YOU NEED TO KNOW?**

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

**WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?**

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Martha C. Hinchey, M.S. at [email@address.com](mailto:email@address.com), the faculty supervisor H. Thompson Prout, Ph.D. at [email@address.com](mailto:email@address.com). If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

\_\_\_\_\_  
Signature of person agreeing to take part in the study

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person agreeing to take part in the study

\_\_\_\_\_  
Name of (authorized) person obtaining informed consent

\_\_\_\_\_  
Date

## Appendix E

### Teacher Consent to Participate in a Research Study

#### **THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT**

##### **WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?**

You are being invited to take part in a research study about the effectiveness of school-based mental health services (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. You are being invited to take part in this research study because you are the teacher of a student already enrolled in the study. If you volunteer to take part in this study, you will be one of about 5 people to do so.

##### **WHO IS DOING THE STUDY?**

The person in charge of this study is Martha C. Hinchey, M.S. (*Principal Investigator, PI*) from the University of Kentucky Department of School Psychology. Ms. Hinchey is a fourth year doctoral student in this department. She is being guided in this research by H. Thompson Prout, Ph.D. There may be other people on the research team assisting at different times during the study.

##### **WHAT IS THE PURPOSE OF THIS STUDY?**

The purpose of this study is to determine the effectiveness of a school-based mental health (i.e., solution-focused brief therapy) with at-risk youth in an alternative school environment. By doing this study, we hope to learn if this type of therapy is effective with this population.

##### **ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?**

You may be excluded from this study if you are not a teacher of a student already enrolled in the study.

##### **WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?**

The research procedures will be conducted at X School in CITY, STATE. The total amount of time you will be asked to volunteer for this study is 15 minutes over the next 3 months.

##### **WHAT WILL YOU BE ASKED TO DO?**

You will also be asked to complete a form on presenting concerns for the identified student and complete a brief assessment on your student's behavior at the beginning and end of the study and 6 weeks following the end of the study. The form and assessment take around 5 minutes to complete. It should be noted that you may be asked to report on more than one of your students as well.

##### **WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

You may find some questions we ask you to be upsetting or stressful. In addition to the risks listed above, you may experience a previously unknown risk or side effect.

##### **WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?**

There is no guarantee that you will get any benefit from taking part in this study. Your willingness to take part, however, may, in the future, help society as a whole better understand this research topic.

##### **DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

##### **IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want to be in the study, there are no other choices except not to take part in the study.

##### **WHAT WILL IT COST YOU TO PARTICIPATE?**

There is no cost to participate.

##### **WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?**

You will not receive any rewards or payment for taking part in the study.

##### **WHO WILL SEE THE INFORMATION THAT YOU GIVE?**

We will make every effort to keep confidential all research records that identify you to the extent allowed by law. Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private. We will make every effort to prevent anyone who is not on the research team from knowing that you and your child gave us information, or what that information is. All information will be kept confidential in accordance with the University of Kentucky Office of Research Integrity's standards for collection and storage of hard copy and electronic data (2011). All data will be kept on a university owned password-protected computer in the researcher's locked office, with



reported identifiable data (e.g., name of student, parent, or teacher) stored separately from data obtained in an encrypted password protected file. All consent/assent forms will be stored separately from all data obtained and all hard copy data (i.e., rating scales, assessments, notes from review of records, presenting concerns forms) will also be stored separately from identifying information in a locked filing cabinet within the researcher's locked office located at XXX Building, University of Kentucky, Lexington, KY 40536. The only person who will have access to the data/identifiable data is the researcher. All participants will be assigned a research record number that will be used on all ratings scales, assessments, forms, or notes utilized in the study. The research record number and identifying information will be stored separately from one another.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky.

**CAN YOUR TAKING PART IN THE STUDY END EARLY?**

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study. The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you or if they find that your being in the study is more risk than benefit to you.

**WHAT IF NEW INFORMATION IS LEARNED DURING THE STUDY THAT MIGHT AFFECT YOUR DECISION TO PARTICIPATE?**

If the researcher learns of new information in regards to this study, and it might change your willingness to stay in this study, the information will be provided to you. You may be asked to sign a new informed consent form if the information is provided to you after you have joined the study.

**WHAT ELSE DO YOU NEED TO KNOW?**

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

**WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?**

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Martha C. Hinchey, M.S. at [email@address.com](mailto:email@address.com), or the faculty supervisor H. Thompson Prout, Ph.D. at [email@address.com](mailto:email@address.com). If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

\_\_\_\_\_  
Signature of person agreeing to take part in the study

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person agreeing to take part in the study

\_\_\_\_\_  
Name of (authorized) person obtaining informed consent

\_\_\_\_\_  
Date

Appendix F

Minor Assent Form

**THE IMPLEMENTATION OF SOLUTION-FOCUSED BRIEF THERAPY (SFBT) WITH AT-RISK YOUTH IN AN ALTERNATIVE SCHOOL ENVIRONMENT**

You are invited to be in a research study being done by Martha C. Hinchey, M.S. from the University of Kentucky. You are invited because you are currently enrolled in X School in CITY, STATE.

If you agree to be in the study, you will be asked to complete a series of brief assessments and attend counseling sessions. However, your counseling sessions will not start immediately, but only after 1-2 weeks from today. During the counseling sessions, you and Ms. Hinchey will identify areas that are challenging for you and will work together to create solutions to help you overcome those challenging areas.

You will come to Ms. Hinchey’s office 3-5 times to complete a brief assessment before the counseling sessions begin, 6 times (twice per week) for around 40 minutes for counseling sessions, and 1 time after the end of the study to complete a final brief assessment. Additionally, by agreeing to be part of the study, you are giving Ms. Hinchey permission to review your cumulative school records, which contain a general description of your background and academic performance thus far in school, to speak with one of your teachers regarding how you are doing in school, and to speak with a parent or legal guardian regarding how you are doing at home. Lastly, by agreeing to be part of this study, you are allowing Ms. Hinchey to audio-record each of the counseling sessions with you.

If you discuss with Ms. Hinchey that you want to harm yourself, harm others, have suicidal thoughts, or are experiencing abuse, Ms. Hinchey will have to follow the policies and procedures in place at the school and local, state, and federal policies regarding confidentiality. This means that Ms. Hinchey may have to break confidentiality and share this information with her supervisor, the principal, and your parents. Ms. Hinchey wants to make sure that she is doing everything she can to help you to the best of her ability and promote your best interest at all times.

There is no payment for participation in this study.

Your family will know that you are in the study. If anyone else is given information about you, they will not know your name. A number or initials will be used instead of your name.

If something makes you feel bad while you are in the study, please tell Ms. Hinchey. If you decide at any time you do not want to finish the study, you may stop whenever you want.

You can ask Ms. Hinchey questions any time about anything in this study. You can also ask your parent any questions you might have about this study.

Signing this paper means that you have read this or had it read to you, and that you want to be in the study. If you do not want to be in the study, do not sign the paper. Being in the study is up to you, and no one will be mad if you do not sign this paper or even if you change your mind later. You agree that you have been told about this study and why it is being done and what to do.

\_\_\_\_\_  
Signature of Person Agreeing to be in the Study

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Person Obtaining Informed Assent

\_\_\_\_\_  
Date

Appendix G

DEVELOPMENTAL HISTORY FORM – PARENT VERSION

- ❖ **AGE:**
- ❖ **GRADE:**
- ❖ **GENDER:**
- ❖ **RACE:**
- ❖ **ETHNICITY:**
- ❖ **PREVIOUSLY RECEIVED OUTSIDE COUNSELING SERVICES? (If yes, please describe.)**
  
- ❖ **CURRENTLY RECEIVING OUTSIDE COUNSELING SERVICES? (If yes, please describe.)**
  
  
- ❖ **PREVIOUS AND/OR CURRENT DIAGNOSES? (If yes, please describe.)**
  
  
  
- ❖ **ANY OTHER INFORMATION YOU WOULD LIKE TO PROVIDE?**

Appendix H

PRESENTING CONCERNS/ISSUES – PARENT VERSION  
(BASELINE)

❖ **Please describe your primary concern about your child and his or her behavior.** *(If there is more than 1 primary concern, please discuss as well)*

1. Concern: \_\_\_\_\_

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_

3. Concern: \_\_\_\_\_

\_\_\_\_\_

❖ **How long have you been concerned about this issue(s)?** *(If there is more than one primary concern, please list each and length of time you have been concerned separately)*

1. Concern: \_\_\_\_\_ Length of Time: \_\_\_\_\_

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_ Length of Time: \_\_\_\_\_

3. Concern: \_\_\_\_\_ Length of Time: \_\_\_\_\_

\_\_\_\_\_

❖ **Please indicate the severity level of the primary concern by circling one of the following:** *(If there is more than one primary concern, please list each and circle the corresponding severity level separately)*

1. Concern: \_\_\_\_\_

Mild                      Moderate                      Severe                      Extremely Severe

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_

Mild                      Moderate                      Severe                      Extremely Severe

3. Concern: \_\_\_\_\_

Mild                      Moderate                      Severe                      Extremely Severe

**THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY!**

Appendix I

PRESENTING CONCERNS/ISSUES – PARENT VERSION (POSTTEST)
-----------------------------------------------------------

❖ **Please indicate the severity level of the primary concern by circling one of the following:** *(If there is more than one primary concern, please list each and circle the corresponding severity level separately)*

1. Concern: \_\_\_\_\_

<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extremely Severe</b>
-------------	-----------------	---------------	-------------------------

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_

Mild	Moderate	Severe	Extremely Severe
------	----------	--------	------------------

3. Concern: \_\_\_\_\_

Mild	Moderate	Severe	Extremely Severe
------	----------	--------	------------------

Appendix J

PRESENTING CONCERNS/ISSUES – TEACHER VERSION  
(BASELINE)

❖ **Please describe your primary concern about the student and his or her behavior.** *(If there is more than 1 primary concern, please discuss as well)*

1. Concern: \_\_\_\_\_

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_

3. Concern: \_\_\_\_\_

❖ **How long have you been concerned about this issue(s)?** *(If there is more than one primary concern, please list each and length of time you have been concerned separately)*

1. Concern: \_\_\_\_\_ Length of Time: \_\_\_\_\_

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_ Length of Time: \_\_\_\_\_

3. Concern: \_\_\_\_\_ Length of Time: \_\_\_\_\_

❖ **Please indicate the severity level of the primary concern by circling one of the following:** *(If there is more than one primary concern, please list each and circle the corresponding severity level separately)*

1. Concern: \_\_\_\_\_

Mild                      Moderate                      Severe                      Extremely Severe

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_

Mild                      Moderate                      Severe                      Extremely Severe

3. Concern: \_\_\_\_\_

Mild                      Moderate                      Severe                      Extremely Severe

**THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY!**

Appendix K

PRESENTING CONCERNS/ISSUES – TEACHER VERSION (POSTTEST)
------------------------------------------------------------

❖ **Please indicate the severity level of the primary concern by circling one of the following:** *(If there is more than one primary concern, please list each and circle the corresponding severity level separately)*

1. Concern: \_\_\_\_\_

Mild	Moderate	Severe	Extremely Severe
------	----------	--------	------------------

*(If more than 1 primary concern...)*

2. Concern: \_\_\_\_\_

Mild	Moderate	Severe	Extremely Severe
------	----------	--------	------------------

3. Concern: \_\_\_\_\_

Mild	Moderate	Severe	Extremely Severe
------	----------	--------	------------------

## Appendix L

<b>Solution-Focused Brief Therapy (SFBT) Intervention: Protocol for First Sessions</b>
----------------------------------------------------------------------------------------

<b>Participant ID#</b> _____ <b>Date:</b> _____ <b>Session #</b> _____
------------------------------------------------------------------------

Client Concern/History: (“How can I help? What tells you that \_\_\_\_\_ is a problem? What have you tried? Was it helpful?”)

Goal Formulation: (“What do you want different as a result of coming here? Dialogue around the miracle question”).

Exceptions: (“Are there times when the problem does not happen or is less serious? When? How does that happen? Are there times that are a little like the miracle picture you describe?”)

Scaling:

*How close are things to the miracle:*

*Pre-session change:*

*Willingness to work:*

*Confidence:*

Compliments:

Bridge:

Suggestion(s):

Next Time:

*Note.* Replication and use of these protocols were granted by the authors (De Jong & Berg, 2008, p. xv).  
De Jong, P., & Berg, I. K. (2008). *Interviewing for solutions* (3rd ed.). Belmont, CA: Thomson Brooks/Cole.  
De Jong, P., & Berg, I. K. (2008). *Instructor's resource manual without test bank: Interviewing for solutions* (3rd ed.). Belmont, CA: Thomson Brooks/Cole.



**Solution-Focused Brief Therapy (SFBT) Intervention: Protocol for Later Sessions**

**Participant ID# \_\_\_\_\_ Date: \_\_\_\_\_ Session # \_\_\_\_\_**

What's Better?

*Elicit:* ("What's happening that's better?")

*Amplify:* ("How does that happen? What do you do to make that happen? Is that new for you? Now that you are doing \_\_\_\_\_, what do you notice different between you and [significant other]? What's different at your house?")

*Reinforce/Compliment:* ("Not everyone could have said or done \_\_\_\_\_. So you're the kind of person who is/does/ believes \_\_\_\_\_?")

*Start Again:* ("What else is better?")

Doing More: ("What will it take to do \_\_\_\_\_ again? To do it more often?")

If Nothing Is Better: ("How are you coping? How do you make it? How come things aren't even worse?")

Scaling Progress:

*Current Level:*

*Next Level:* ("When you move from \_[number for current level] to \_[one number up the scale], what will be different? Who will be first to notice? When she or he notices, what will she or he do differently? What would it take to pretend a \_\_\_[one number up the scale] has happened?")

*Termination:* ("What number do you need to be at to not see me anymore? What will be different then?")

Compliments:

Bridge:

Suggestions:

Next Time:

*Note.* Replication and use of these protocols were granted by the authors (De Jong & Berg, 2008, p. xv).  
De Jong, P., & Berg, I. K. (2008). *Interviewing for solutions* (3rd ed.). Belmont, CA: Thomson Brooks/Cole.  
De Jong, P., & Berg, I. K. (2008). *Instructor's resource manual without test bank: Interviewing for solutions* (3rd ed.). Belmont, CA: Thomson Brooks/Cole.

**Solution-Focused Brief Therapy (SFBT) Intervention:**

**Questions for Developing Well-Formed Goals**

To the interviewer: When using these questions, remember that you most want to explore for the client's perception of *what will be different* when either a miracle happens or the problem is solved. Also remember that developing well-formed goals is hard work for clients. Be patient and persistent in asking the interview questions.

---

THE MIRACLE QUESTION

“Suppose that, while you are sleeping tonight, a miracle happens. The miracle is that the problem, which brought you here today, is solved. Only you don't know that it is solved because you are asleep. What difference will you notice tomorrow morning that will tell you that a miracle happened? What else will you notice?”

---

AMPLIFYING AROUND THE CHARACTERISTICS OF WELL-FORMED GOALS

Small: “Wow! That sounds like a big miracle. What is the first small thing you would notice that would tell you that things are different?”

“What else would tell you that things were better?”

Concrete, Behavioral, Specific: “You say that the miracle is that you'd feel better. When you feel better, what might others notice different about you that would tell them that you feel better?”

“What might you do different when you feel better?”

“What else?”

Start of Something Different/Better: “You say that the miracle is that you'd weigh 50 pounds less. OK, what will be different in your life when you lose that first pound? What else?”

Presence of Something Different/Better: “You say that, when the miracle happens, you'll fight less with the kids. What will you be doing *instead*?”

---

AMPLIFYING AROUND PERCEPTIONS OF SIGNIFICANT OTHERS

“When the miracle happens, what differences will your husband (children, best friend, coworkers, teachers, etc.) notice? What differences will your husband notice about you? What else will they notice that's different?”

---

AMPLIFYING AROUND THE CLIENT'S SYSTEM OF RELATIONSHIPS

“When your husband (children, best friend, coworkers, teachers, etc.) notice \_\_ (the difference that the client mentions in answering the previous question), what will your husband (they) do differently? What else? And when he does that, what will you do? And when you do that, what else will be different?”

---

TIPS

If client says, “I don't know,” say:

“Suppose you did know. What would you say?”

Or go to relationship questions, for example:

“Suppose I were to ask your husband (children, best friend, etc.), what would he (they) say?”

If clients struggle with the questions or say they are tough, agree with them and say:

“I’m asking you some tough questions; take your time.”

If clients cannot work with the miracle question, work with questions phrased along the lines of “when the problem is solved.”

When clients get unrealistic (“I’d win the lottery!”), just agree with them by saying:

“That would be nice, wouldn’t it?” If they persist, ask:

“What do you think the chances are of that happening?” Or, ask: “What tells you that \_\_ could happen in your life?”

When clients give you a concrete piece of the miracle picture or potential solution (e.g., “When the miracle happens, I guess I’d be taking more walks”), be sure to build by asking, for example:

“What’s different for you when you take more walks?” (*and continue to build from that answer*)

Part of respecting the client’s perceptions is to respect the words that they use for their perceptions and adopt them in your interview questions. Thus, the preceding question picks up on the client’s reference to taking more walks.

---

***VERY IMPORTANT:*** If, despite your best efforts, clients are unable to work with the miracle question or define how things will be different when problem is solved, ask:

“How do you know this problem can be solved?”

---

## GOAL FORMULATION IN LATER SESSIONS

*Work from the scaling question about progress:*

“On a scale of 0 to 10, where 0 is where you were at when we began working together, and 10 means that the problem is solved (or the miracle happens), where are you at today?”

“OK, so you’re at a 5. What is happening in your life that tells you that you are a 5? So when you move up just a bit, say from 5 to 6, what will be different in your life that will tell you that you are a 6?”

What else? What will be different when you move on to a 7?”

Thereafter, amplify just as you would for the miracle question, for example, around significant others. For example: “When you move up to a 6, what will your best friend notice that will tell her or him that you are doing just that much better? What else?”

*Note.* Replication and use of these protocols were granted by the authors (De Jong & Berg, 2008, p. xv).  
De Jong, P., & Berg, I. K. (2008). Interviewing for solutions (3rd ed.). Belmont, CA: Thomson Brooks/Cole.  
De Jong, P., & Berg, I. K. (2008). Instructor’s resource manual without test bank: Interviewing for solutions (3rd ed.). Belmont, CA: Thomson Brooks/Cole.

## Appendix M

<i>Solution-Focused Fidelity Instrument v.10</i> (Lehmann & Patton, 2012).
----------------------------------------------------------------------------

Circle the answer which applies to the therapist (Session # \_\_\_\_\_)

1	2	3	4	5	6	7
not at all	yes, but clearly not enough			yes, clearly		yes, clearly and specifically

**1. The therapist asked what the client/family wanted out of today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**2. The therapist asked "what's better" in today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**3. The client's/family's stated needs for today's session were related to overall goal(s) for therapy.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**4. The therapist summarized the client's/family's comments during today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**5. The therapist complimented the client's/family's strengths/resources during today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**6. The therapist asked exception/difference questions during today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**7. The therapist asked amplifying questions during today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**8. The therapist asked reinforcing questions (e.g. summarizing/complimenting) or client's reported change in today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**9. The therapist was able to help the client/family behaviorally describe a next small step of progress towards their goals.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**10. The therapist asked scaled questions during today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**11. The therapist asking coping questions related to the client's/family's abilities that emerged during today's session.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**12. The therapist asked questions to help the client think about how changes will affect the client's family and important others in their life.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

**13. The therapist asked for feedback on the helpfulness of the session today from the client/family.**

1	2	3	4	5	6	7
---	---	---	---	---	---	---

*Note.* Replication of this measure granted by the authors. The original version of this scale was written from the therapist's perspective. Permission was granted from the developers to supplement "The therapist" for "I", allowing the measure to be completed by outside evaluators. (Lehmann and Patton, 2012).

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## Vita

### MARTHA C. HINCHEY

#### EDUCATION

- 2011  
Dec ***Master of Science in Education (M.S.)***  
School Psychology, University of Kentucky  
Lexington, Kentucky
- 2010  
May ***Master of Science in Education (M.S.)***  
Counseling Psychology, University of Kentucky  
Lexington, Kentucky
- 2007  
May ***Bachelor of Arts (B.A.)***  
Psychology, University of the South (Sewanee)  
Sewanee, Tennessee

#### CLINICAL/PROFESSIONAL EXPERIENCE

- 2014-Present ***Predoctoral Internship ~ Psychology***  
*Accredited by the American Psychological Association (APA) ~ Member of the Association of Psychology Postdoctoral and Internship Centers (APPIC)*  
*Louise R. Goldhagen Multidisciplinary Evaluation and Consulting Center, Florida State University*  
Supervisors: Anne Selvey, Ph.D., Licensed Psychologist and  
Lauren M. Hutto, Ph.D., Licensed Psychologist, Licensed School Psychologist
- 2013-2014 ***Doctoral Internship ~ School Psychology***  
“Alternative” Middle and High School in Kentucky (Combined School)  
Supervisor: Dustin Howard, Ed.S.
- 2013  
Jan-July ***Advanced Graduate Practicum ~ School Psychology***  
School Psychology Clinic, University of Kentucky  
Supervisor: Lisa Ruble, Ph.D., Licensed Psychologist
- 2013  
Jan-May ***Advanced Graduate Practicum ~ School Psychology***  
Center for Academic and Tutorial Services (CATS), University of Kentucky  
Supervisor: Katherine L. Stone, Ph.D., Licensed Psychologist
- 2012 ***Advanced Graduate Practicum ~ School Psychology***  
Center for Academic and Tutorial Services (CATS), University of Kentucky  
Private Practice ~ Psychology  
Supervisor: Katherine L. Stone, Ph.D., Licensed Psychologist
- 2012-2013  
June-July ***Clinic Coordinator, Assistant Clinical Director***  
School Psychology Clinic, University of Kentucky

- 2011-2012  
Aug-May **Graduate Practicum ~ School Psychology**  
High School, Jessamine County, Kentucky  
Supervisor: Allison Hardin, Psy.S., School Psychologist
- 2010  
Aug-Dec **Graduate Practicum ~ School Psychology**  
Elementary School, Fayette County, Kentucky  
Supervisor: Melisa Morris, Ed.S., NCSP
- 2009  
May-Dec **Graduate Practicum ~ Counseling Psychology**  
Family Counseling Service, Inc., Lexington, Kentucky  
Supervisor: LaDonna Tyler, LCSW, Licensed Clinical Social Worker
- 2008-2010  
Aug-May **Graduate Assistantship**  
The Early Childhood Laboratory, University of Kentucky  
Supervisor: Charlotte Manno, M.Ed.
- 2007-2014 **Clinical Assistant**  
Private Practice ~ Katherine L. Stone, Ph.D., Licensed Psychologist
- 2005-2007 **Assistant Teacher ~ Summer Program (May-August)**  
The Matthew Reardon Center ~ Savannah, Georgia

## RESEARCH EXPERIENCE

- 2014  
May-June **Independent Data Consultant/Data Analyst**  
Kentucky School System
- 2013  
May-June **Independent Data Consultant/Data Analyst**  
Kentucky School System
- 2012-2014 **Graduate Research Assistantship**  
Medical Behavioral Science, University of Kentucky (UK)  
Supervisor: Jamie L. Studts, Ph.D., Licensed Psychologist, Associate Professor
- 2012  
May-June **Independent Data Consultant/Data Analyst**  
Kentucky School System
- 2011-2012  
Aug-June **Graduate Research Assistantship**  
College of Nursing, University of Kentucky  
Supervisor: Elizabeth Salt, Ph.D., RN, APRN, Assistant Professor
- 2009-2011 **Research Aide**  
School Psychology, University of Kentucky
- 2010-2011  
Aug-July **Graduate Research Assistantship**  
Medical Behavioral Science, University of Kentucky  
Supervisor: Jamie L. Studts, Ph.D., Licensed Psychologist, Associate Professor
- 2009-2010 **Research Aide**  
Counseling Psychology, University of Kentucky

## PRESENTATIONS

- 2014      *Solution-Focused Brief Therapy Association (SFBTA) Annual Conference*  
Seminar Presentation  
**Hinchey, M. C.** (2014, November). The implementation of solution-focused brief therapy (SFBT) with at-risk youth in an alternative school environment.
- 2014      *National Association for School Psychologists (NASP) Annual Conference*  
Poster Presentation  
Hoffman, J. M., **Hinchey, M. C.**, Sigler, A., & Ruble, L. A. (2014, February). Individualized social skills assessment and intervention for children with Autism.
- 2013      *“School-Based Solution-Focused Brief Therapy (SFBT)”*  
Seminar Presentation  
School Psychology, University of Kentucky (UK)
- 2013      *“School-Based Solution-Focused Brief Therapy (SFBT)”*  
Seminar Presentation  
School-Based Practitioners in Fayette County, Kentucky
- 2013      *Society of Behavioral Medicine (SBM) Annual Conference*  
Poster Presentation  
Studts, J. L., Knudsen, H. K., **Hinchey, M. C.**, & Reynolds, G. (2013). Facilitating evidence-based tobacco cessation interventions in dental care settings with QuitAdvisorDDS: A feasibility study.
- 2013      *Autism Society of the Bluegrass (ASBG)*  
Seminar Presentation
- 2012      *Kentucky Psychological Association (KPA) Annual Conference*  
Poster Presentation  
**Hinchey, M.C.**, Studts, J. L., Knudsen, H. K., & Reynolds, G. (2012). Facilitating evidence-based tobacco cessation interventions in dental care settings.
- 2012      *“School-Based Solution-Focused Brief Therapy (SFBT)”*  
Seminar Presentation  
School Psychology, University of Kentucky (UK)
- 2010      *American Psychological Association (APA) Annual Conference*  
Poster Presentation  
Reese, R. J., Norsworthy, L. N., Gifford, B. L., **Hinchey, M. C.**, & Sievers, H. (2010, August). Client feedback in supervision: Are therapy outcomes and supervision enhanced?

## AWARDS/RECOGNITIONS

- 2013            ***Solution-Focused Brief Therapy Association's (SFBTA) Research Award***  
Dissertation Proposal ~ "The implementation of solution-focused brief therapy (SFBT) with at-risk youth in an alternative school environment."
- 2010-Present   ***Elected Doctoral Student Senate Representative***  
School Psychology, University of Kentucky

## PUBLICATIONS IN PROGRESS

- Studts, J. L., Knudsen, H. K., **Hinchey, M. C.**, & Reynolds, G. (n.d.). Facilitating evidence-based tobacco cessation interventions in dental care settings. (not yet submitted)
- Studts, J. L., **Hinchey, M. C.**, Knudsen, H. K., Ridner, S. L., Worth, C. T., & Sorrell, C. L. (n.d.). Promoting implementation of evidenced-based tobacco cessation interventions: A continuing education intervention for nurse practitioners. (not yet submitted)

## CONTINUING EDUCATION

- 2015            ***Autism Institute, Florida State University College of Medicine, Training***  
Tallahassee, Florida
- 2015            ***Pearson Clinical Assessment Group, Training***  
Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V) and Kaufman Test of Educational Achievement, Third Edition (KTEA-III)  
Tallahassee, Florida
- 2014            ***Solution-Focused Brief Therapy Association (SFBTA) Annual Conference***  
Santa Fe, New Mexico
- 2014            ***National Association for School Psychologists (NASP) Annual Conference***  
Washington, D.C.
- 2013            ***Solution-Focused Brief Therapy Association (SFBTA) Annual Conference***  
Toronto, Ontario - Canada
- 2012            ***Solution-Focused Brief Therapy Association (SFBTA) Annual Conference***  
Minneapolis, Minnesota
- 2012            ***Down Syndrome Association of Central Kentucky Annual Conference***  
Lexington, Kentucky
- 2011            ***Cambridge Health Alliance, Psychiatry Continuing Education Division***  
***Annual Conference***  
Boston, Massachusetts
- 2009            ***Seminar on Autism Spectrum Disorder (ASD)***  
The Ridge, Lexington, Kentucky