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Solution-Focused Brief Therapy and Students' Behaviors

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Solution-Focused Brief Therapy and Students' Behaviors

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Capstone Project

For the Degree of Doctorate of Education in Interdisciplinary Leadership

Governors State University

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IRB Approval
Chapter 1. Introduction

There are over 450 million people in the world who have a behavioral health issue – this is equal to 1 in 4 people (Giliberti, 2018). The American Psychiatric Association describes behavioral health issues as health conditions involving changes in emotions, thinking and/or behavior (Perekh, 2018). Behavioral health issues are associated with distress and/or problems functioning in family, social or work activities. Behavioral health issues may be associated with exposure to adverse environments (Perekh, 2018). Childhood adversity is a potent risk factor for mental health conditions via disruptions to stress response systems. (Horn, 2019). Childhood adversity and childhood trauma can cause serious chronic stress in children. A traumatic event is a frightening, dangerous, or violent event that poses a threat to a child’s life or bodily integrity. Traumatic experiences can initiate strong emotions and physical reactions that can persist long after the event. Children may feel terror, helplessness, or fear, as well as physiological reactions such as heart pounding, vomiting, or loss of bowel or bladder control. Children who suffer from child traumatic stress are those who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the events have ended. Traumatic reactions can include a variety of responses, such as intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, physical symptoms, etc. (Perekh, 2018).

Adverse environments such as communities plagued with violence, poverty, trauma, etc. can have lasting consequences for children’s behavioral health and development of adversity by the time they reach adulthood (McLaughlin, 2013; Mclaughlin, 2017). According to McLaughlin (2013), “childhood adversity” has been used to describe a host of experiences that
can cause serious or chronic stress during childhood. These adverse experiences can vary from exposure to threatening or traumatic conditions in the environment (e.g., sexual or physical abuse, natural disasters) to a lack of healthy environmental inputs (e.g., poverty, neglect).

Childhood adversity is a common societal problem that plays an important role in shaping and is a risk for behavioral health problems across the lifespan. Furthermore, about half of all children in the United States will have experiences involving harm or threat of harm to the child, such as physical or sexual abuse, domestic violence, or exposure to violence in the community, and experiences that involve deprivation and social disadvantage, such as neglect, the absence or limited availability of a caregiver, poverty and insecure access to food (Kessler, 2010). The participants in this study attend school in the community of North Lawndale. North Lawndale is a predominantly African-American community plagued with violence, a high rate of unemployment, (35% of adults are unemployed) homelessness (25%) racial profiling, a high rate of police arrests, drug usage, etc. (Perekh, 2018).

Children who experience adversity are more likely to develop behavioral health problems than children who have never encountered adversity (McLaughlin, 2012). Specifically, children exposed to adversity exhibit information processing biases that facilitate the rapid identification of anger (Shackman, Shackman & Pollak, 2007), heightened emotional reactivity to negative cues that could signal the presence of a threat (McLaughlin, Peverill, Gold, Alves & Sheridan, 2015), and generalization of threat responses to a wide range of stimuli (McLaughlin, 2016). For example, students who live and attend schools in violent communities such as North Lawndale on Chicago’s west side, are exposed to violence and may have difficulty discriminating between threat and safety cues even in spaces where they should expect to feel safe (e.g.; school).

However, not all children exposed to adverse environments ultimately develop a behavioral
health issue. Some children go on to have severe mental health issues resulting in suicidal thoughts and attempts (Gilberti, 2018).

Research suggests that the rate of suicide and suicidal thoughts among children is increasing. In 2017, adolescents and young adults aged 15-24 had a suicide rate of 14.4% (Gilberti, 2018). Gilberti (2018) detailed some potential factors for the increase in suicide rates amongst children including the 2007-2009 economic down turn, inadequate access to behavioral health care, and changing cultural norms (Gilberti, 2018). Most of these purported explanations do little to explain what's behind child suicide, and that's a problem, because child suicide has increased (Nuyan, 2018). Too often, students who exhibit signs of the possible emergence of behavioral health problems are isolated and do not receive assertive and compassionate help (Nuyan, 2018).

Children experience many challenges such as trying to gain autonomy while still being under the care and direction of adults (Moore, 2016). Children with parents who do not notice or do not care about their symptoms may not get treatment, and those in failing schools may not get support for behavioral issues. Over time, children have been known to experience the following stressors: (1) a more competitive academic environment than ever, (2) an increase in suicide ideology, (3) opioid abuse epidemic, (4) longer wait times and delays in receiving behavioral health services due to lack of resources and insurance (Nuyan, 2018). Parents searching for behavioral health care via their insurance carriers often experience challenges such as access to and availability of behavioral health providers (Moore, 2016).

For parents who are able to access qualified care providers, there appears to be another barrier — economic inequality. Insurance companies are technically required to cover behavioral health care, but reports suggest they often refuse to offer coverage equality for mental and
physical concerns. It's common for claims to be denied, for insurance to only pay for medication, or for companies to place limitations on how many therapy sessions a child can receive (Moore, 2016). Each of these practices increases a child's vulnerability to chronic behavioral health issues. There is indeed a child behavioral health crisis. This crisis is affecting children not only at home, but also within the school setting (Moore, 2016). There is a behavioral health crisis in Illinois' schools. Seventeen percent of all adolescents in Illinois have seriously considered attempting suicide, and 10% of all adolescents attempted suicide at least once during the last 12 months (Nyen, 2018). Young people are in a behavioral health crisis, and there are not enough resources to combat severe behavioral health issues.

Driven largely by an increase in calls from schools, the behavioral health crisis hotline for children has soared by 37% over the past five years to nearly 42,000 calls—about 115 calls per day (Karp, 2012). Chicago Public School staff members say they are seeing more students who appear to be dangerously depressed, psychotic or aggressive, prompting them to call the hotline more often (Karp, 2012). Youth with emotional difficulties suffer from higher rates of suspensions, expulsions, truancy and behavioral referrals which can impact academic performance (Karp, 2012). Teachers, already responsible for academic achievement and classroom management, typically receive little training in dealing with behavioral health problems; thus, many schools develop relationships with community behavioral health agencies, amongst other resources to support educators as they manage behavioral health conditions in students (Moore, 2016).

Many Chicago Public Schools have benefited from partnering with agencies such as the I AM ABLE Center for Family Development (I AM ABLE) to address the behavioral health crisis within schools by providing clinical counseling (Karp, 2012). Behavioral Health Providers at I
AM ABLE utilize Solution-Focused Brief Therapy (SFBT) to help students increase their overall level of functioning. These Licensed Professional Counselors and Social Workers provide behavioral health services and are responsible for diagnosing (if applicable) and treating students who have been identified as needing behavioral health services. Students displaying adverse behaviors, (i.e., inability to emotionally regulate themselves, hitting others, cheating, bullying behaviors, symptoms of depression, etc.) are referred to these Behavioral Health Providers (Burg & Mayhall, 2002). The community behavioral health agencies are working to utilize empirically studied interventions (Fazel, Ford, Hoagwood & Stephan, 2015) when providing counseling within a school setting. One such intervention being utilized amongst Behavioral Health Providers, is SFBT.

**Solution-Focused Brief Therapy**

Solution-Focused Brief Therapy is a model developed by Steve de Shazer and colleagues at the Brief Family Therapy Institute in Milwaukee. It is a therapeutic system which focuses on helping clients identify solutions in a straight-forward manner within a limited amount of time (Cavallaro & Sobhy, 2010). SFBT is based on the assumption that clients have the necessary strengths and resources to change and that counseling is most effective when focusing on constructing solutions unique to each client (Shazer, 1988). The increase in research studies has resulted in SFBT being recognized as a promising, evidence-based practice as is indicated by the recent review by the National Registry of Evidence-Based Programs and Practices. According to Bond (2013), SFBT is a promising intervention for schools and has been applied to improve academic and goal achievement; and to decrease truancy, classroom disruptions, and substance use.
There are various interventions and techniques utilized in SFBT; goal setting, scaling, presuppositional questions, asking the "miracle question", and positive feedback. These various interventions and techniques can be modified for use with children and adolescents. Behavioral Health Providers utilizing SFBT in a school setting work to create a treatment plan for each identified student (Murphy, 2008; Kim & Franklin, 2009). Students meet with the same Behavioral Health Provider once a week for a 25-30 minutes session, guided by the treatment plan. This treatment plan typically focuses on the factors relevant to the treatment such as; the reason for referral, or the problem the client is experiencing that brought him or her to treatment, a diagnosis (if any), list of medications taken (if any), current symptoms, support for the client (family, friends, other behavioral health professionals, etc.), modality or treatment type, frequency of treatment, goals and objectives, measurement criteria for progress on goals, client strengths, and barriers to progress (Murphy, 2008; Kim & Franklin, 2009).

The Behavioral Health Providers at I AM ABLE reported meeting with students at least once a week for 25-30 minutes per session to specifically work on behaviors that produced low scores as measured by the Behavioral Rating Index for Children (BRIC). I AM ABLE reported that while they diagnose where applicable, strive to be knowledgeable of any current medications the student may be taking, and offer support for the family where necessary, their primary focus with students is treating the students current symptoms surrounding adverse behaviors as reported on the Behavior Rating Index for Children (BRIC). This assessment will discussed in further detail in upcoming chapters.

While one should understand the process and flow of SFBT, the model is heavily driven by its interventions. The interventions are straightforward and simple to deliver. In chapter 2, I
will describe the interventions of goal setting, scaling questions, presuppositional questions, the miracle question, and positive feedback, in counseling situations (Burg & Mayhall, 2002).

**The Behavior Rating Index for Children**

Behavioral Health Providers who work with children within school settings are confronted with a need for short, reliable, easy-to-administer measures that apply to a broad range of behavioral issues (Stiffman, 1984). One of the ways in which the success of SFBT can be measured is with the BRIC. Behavioral Health Providers administer the BRIC, a 13-item summated category scale that provides a measure of children’s behavior problems. The BRIC is valid and reliable for clinical practice and research (Stiffman, 1984). The BRIC is the assessment tool that was utilized by Behavioral Health Providers at I AM ABLE to determine if students’ behaviors improved after receiving SFBT.

I AM ABLE is a non-profit organization, located in North Lawndale, founded and incorporated from a strengths-based perspective due to overwhelming challenges and disparities faced by African-American and Latino families. “I AM ABLE” addresses the lack of behavioral health services in schools through its clinical counseling programs.

**Definitions**

A few important terms to be defined are:

**Behavioral Health** - the scientific study of the emotions, behaviors and biology relating to a person’s mental well-being, their ability to function in everyday life and their concept of self (Behavioral Health, 2017).

**Behavioral Health Provider** - professionals who diagnose behavioral health conditions and provide treatment (Luoma, 2016). Licensed Professional Counselors, Licensed Clinical
Professional Counselors, Licensed Social Workers and Licensed Clinical Social Workers are considered behavioral health providers for the purposes of this study.

Behavior Rating Index for Children – a 13-item summated category scale that provides a measure of children’s behavior problems (Stiffman, 1984).

Solution-Focused Brief Therapy – an approach to psychotherapy based on solution building rather than problem solving (Iveson, 2002).

Statement of the Research Question

The research question for this study is: Will students' behaviors differ significantly, as measured by the pretest and posttest BRIC, based upon participation in SFBT?

Rationale for the Study

Around 17 million children in the U.S have or have had a behavioral health issue, but most are not treated. Eighty percent of children with anxiety are not receiving treatment, along with 40% of children with diagnosable ADHD/ADD and 60% of children with diagnosable depression. Untreated behavioral health issues have had a severe impact on the nation’s economy (Giliberti, 2018). According to the National Alliance on Mental Illness, untreated behavioral health issues cost about $100 billion a year in lost productivity. The United States has a high population of both children and adults with untreated behavioral health issues (Behavioral Health, 2017). Children who have untreated behavioral health issues, can potentially grow up to be adults with behavioral health issues. The start of many behavioral health conditions most often occurs in adolescence. Half of individuals living with behavioral health issues experience onset by the age of 14. This number jumps to 75% by the age of 24. Untreated or inadequately treated behavioral health conditions can affect a student’s ability to learn, grow and develop (Sobhy & Cavallaro, 2010). Even during the best of economic times, youth living with
behavioral health issues struggle to access essential behavioral health services and supports. Services are often unavailable or inaccessible for those who need them the most (Sobhy & Cavallaro, 2010). There is a need for students to have better access to behavioral health services which can be offered within the school setting. Schools should not wait for a crisis to occur within a school, (e.g., a school shooting) before addressing the lack of behavioral health services for students. Take into consideration the following scenario;

_There are 200-300 students entering the school building prepared to begin their school day at 8:45 am. The hallways are filled with the chatter of students in grades K-8. Several students are arguing over a Facebook status posted the night before and it is clear that a fight could break out at any second. The students directly involved are screaming and cursing and it is clear that there is an inability for the students to emotionally regulate themselves. Other students stand looking on, laughing, yelling and encouraging the students directly involved to fight. Security quickly approaches this group of students and they are ushered to the principal's office. The principal calls for the school counselor who is upstairs in her office speaking with a student who came to school with a black eye and reported her mother's boyfriend hit her last night. As the counselor is preparing to call the Department of Children and Family Services to file a report, she hears the principal call her over the intercom. Just a few seconds later, a teacher barges into her office with a student who she says has been cursing at her all morning... and this is only the beginning of the day._

Schools can provide a unique opportunity to identify and treat behavioral health conditions by serving students where they already are. School personnel, (teachers, counselors, social workers, principals) can play an important role in identifying the early warning signs of an emerging behavioral health condition and in linking students with effective services and
supports. Behavioral Health Providers should utilize empirically studied therapeutic models with students (Littrell, Malia, & Vanderwood, 1995). Since schools and school personnel are often best able to identify young people who are most at risk, these services should either be available within the school setting or easily accessible through the school. Coordination between the school and behavioral health system is paramount to success. (Giliberti, 2018).

SFBT is one such therapy being utilized in school settings. SFBT is a model developed by Steve de Shazer and colleagues at the Brief Family Therapy Institute in Milwaukee. It focuses on helping clients to identify solutions in a straight-forward manner within a limited amount of time (Cavallaro & Sobhy, 2010). It is based on the assumption that clients have the necessary strengths and resources to change and that counseling is most effective when focusing on constructing solutions unique to each client (Shazer, 1988).

**Theoretical Framework**

The philosophical paradigm that informs this study is positivism. Positivism supports society shaping an individual. The positivist tradition stresses the importance of doing quantitative research such as the utilization of surveys in order to get an overview of society as a whole and to uncover social trends, such as the relationship between SFBT and students' behaviors (Positivism and Interpretivism, 2015). In positivist research, researchers tend to look for relationships, or "correlations" between two or more variables (SFBT and students' behaviors). Positivists utilize quantitative methods such as surveys, structured questionnaires and universally accepted statistical procedures because these have good reliability and representativeness (Positivism and Interpretivism, 2015). The BRIC is the quantitative questionnaire utilized in this study.
The Present Study

I AM ABLE is a non-profit organization founded and incorporated from a strengths-based perspective due to overwhelming challenges and disparities faced by African-American and Latino families. The mission of I AM ABLE is to demonstrate the love of Jesus Christ, providing all families and individuals with life-changing clinical counseling, educational and wellness services. I AM ABLE addresses the lack of behavioral health services in schools through its clinical counseling program. This program, allows Behavioral Health Providers to provide individual and group counseling services in the academic setting to Pre-K through 12th grade students and their families. The goal of the program is to provide clinical counseling services to students in a school setting in order to assist in improving the academic and behavioral outcomes of identified students.

I AM ABLE proposes that there is a measurable reduction in negative behaviors of students who participate in the clinical counseling program, where Behavioral Health Providers utilize SFBT with students. Behavioral Health Providers at I AM ABLE utilize SFBT to provide direct counseling services to students for 25-30 minutes per session for a minimum of 6 sessions and a maximum of 20 sessions. Behavioral Health Providers at I AM ABLE administer the BRIC, a 13-item summated category scale that provides a measure of children’s behavior problems both pre and post therapeutic services in Kellman Elementary School. Kellman Elementary is a Chicago Public School with 335 students in attendance, in grades PK-8. Joseph Kellman Elementary is located in the Chicago neighborhood of North Lawndale. The BRIC is valid and reliable for clinical practice and research (Stiffman, 1984). Quantitative data was collected via self-reporting (BRIC).

Chapter Summary
In conclusion, there appears to be a behavioral health crisis that exist on the national, state and local level. There is especially a need for behavioral health services for students in many Chicago Public Schools to support School Counselors in providing behavioral health services to identified students. While there are many therapeutic approaches that could be utilized by Behavioral Health Providers working within the schools, chapter one places a specific focus on SFBT. I AM ABLE is a behavioral health organization that uses this form of therapy and measures its effectiveness via the BRIC. In chapter two, a review of the literature will be conducted surrounding the behavioral health crisis on various levels, SFBT in schools and the BRIC as a measure of effectiveness.
Chapter 2. Literature Review

This chapter will examine the literature surrounding trauma, its effects on children and their behaviors, Solution-Focused Brief Therapy in schools and the Behavior Rating Scale for Children as an assessment tool used to measure children’s adverse or negative behaviors. Trauma reactions can manifest in many different ways in young children with variance from child to child (Buss, Warren & Horton, 2015). SFBT is theoretically grounded in the work of Milton Erickson and the brief family therapy model of de Shazer and Berg (1997), which focuses on what strengths the client possesses instead of identifying problems.

Trauma and Children

Furthermore, children often reexperience traumas. Triggers may remind children of the traumatic event and a preoccupation may develop (Buss, Warren & Horton, 2015). For example, a child may continuously reenact themes from a traumatic event through play, nightmares, flashbacks and dissociative episodes also are symptoms of trauma in young children. Other common symptoms include hyperarousal (i.e. temper tantrums), increased irritability, disturbed sleep, a constant state of alertness, difficulty concentrating, exaggerated startle responses, increased physical aggression and increased activity levels (Buss, Warren & Horton, 2015). Violence exposure is associated with internalizing problems. Exposure to neighborhood and family violence in early childhood is associated with poor emotional health and poor performance in school. Low socioeconomic status and traumatic events in early childhood also are correlated with low academic achievement in school (Buss, Warren & Horton, 2015).

Solution-Focused Brief Therapy

SFBT is rooted in systems theory in which change is posited as one part of a system that will create a ripple effect of change throughout the entire system (de Shazer, 1982). From this
perspective, change and growth are viewed as an inevitable and ongoing phenomenon; one just needs to be aware of the mechanisms that prevent it from occurring (de Shazer, 1988). In addition, SFBT is strongly linked to constructivistic thinking; that is, each person has self-created realities (Walter & Peller, 1992). There are times during the therapeutic process where change happens for students as they redefine their perspective. Instead of seeing problems, one sees exceptions to the problems, such as past times when she or he has overcome a hurdle similar to the problem that is currently presenting itself.

The SFBT model has a future orientation and work towards solutions rather than a past orientation that explores prior events. SFBT has also been influenced by research in positive psychology, which suggests that emphasizing client strengths and competencies promotes positive outcomes (Seligman, 2002), and by counseling outcome research that indicates clients improve most significantly during the first few sessions (Whiston & Quinby, 2009). There are several main interventions utilized in SFBT; goal setting, scaling, presuppositional questions, miracle questions, and positive feedback.

Goal Setting

Goal setting in SFBT is of primary importance. Many models of change allow for abstract or vague goals, but in SFBT the goals must be concrete and measurable to be useful. Often at the beginning of counseling, in SFBT the Behavioral Health Provider does not provide the goal but can facilitate a semi-structured conversation that leads the student toward a goal. The conversation is typically one that is open-ended (Walter & Peller, 1992). First, the goal must be framed positively. Rather than focusing on the behaviors the student should not be doing, such as pushing or hurting someone else, the Behavioral Health Provider focuses on the behaviors the student should be doing.
A key word Behavioral Health Providers should remember when helping students create a positive goal is “instead.” For example, the Behavioral Health Provider may ask the student, “I understand how frustrating it has been for you. “What will you be doing instead of losing your temper?” Second, the Behavioral Health Provider should also place the goal in process form. They should use interrogative words, such as “how,” and participles, such as “doing”: “How will you be doing this?” is an example of a goal statement in the process form. Third, the Behavioral Health Provider must put goals in the present tense. One way to reinforce the changes made during the current interaction is to ask: “When you leave here today and you are on track, what will you be doing or thinking differently?” In this case the phrase “on track” is the key to keeping the goal in here-and-now verbiage.

Fourth, the goal should be as specific as possible. Specific goals need not entail a specific decision, but the student should leave the office with a plan for making the decision (Walter & Peller, 1992). Fifth, successful completion of goals should not be out of the student’s control. While goal completion depends on the student’s performance and sometimes on the behavior of others, such as an instructor, it should not be based on expectations from parents or others. Sixth, a student-centered goal is stated in the student’s own words. The Behavioral Health Provider can help by listening to the student, using his or her own language, and using it to help the student frame the goal. Behavioral Health Providers need to assist in defining the goal in a way that is meaningful to the student.

Scaling Questions

In its most basic form, scaling is a process of asking the student to rate something on a scale from 1 to 5, with 5 usually representing the most positive perspective (Walter & Peller, 1992). SFBT uses the technique of scaling for dealing with vague or difficult to define issues,
such as motivation or confidence (de Shazer, 1988). Scaling questions may be used at any stage of counseling but are particularly helpful during goal setting. The benefit to scaling questions is not only in creating specificity but also in creating a method for discussing small steps toward change. The technique of scale is not based solely on the specific scaled question but is comprised of a conversation around the scale.

**Presuppositional Questions**

Presuppositional questions are simple in form and concept, but Behavioral Health Providers can easily forget to use them. Presuppositional questions are offered under the presumption that a particular answer exists. In SFBT, the Behavioral Health Provider capitalizes on the difference between “Have you ever felt confident?” and “Tell me about other times in the past when you have felt confident.” Obviously, the second question presupposes that the student has felt confident in the past. The presuppositional question also invites an affirmative answer rather than an easily rendered and dismissive “no.” By presupposing that a strength, exception, or alternative exists, the Behavioral Health Provider encourages the student to focus on positive past experiences rather than past defeats.

**The Miracle Question**

The “miracle question” is probably the signature intervention in SFBT, yet it is often poorly delivered and frequently short-circuited by a lack of follow-through from the Behavioral Health Provider. This intervention is not comprised of a single question but a conversational sequence in which the student explores the outcomes of a miracle. While often a standard component of a first session, Behavioral Health Providers primarily use this intervention to assist the student in thinking of an exception to the presenting issue (de Shazer, 1988). When the student can identify the exception, the Behavioral Health Provider encourages the student to
apply the experience from the past into a hypothetical situation (Walter & Peller, 1992). The miracle question is simply a formatted method for leading a student through a daydream of possibilities. When a student enters this land of miraculous hypothetical reality, he or she is invited to consider possibilities outside of the student's normal reality.

The standard form for the miracle question is as follows: Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different? How would your husband know without your saying a word to him about it? (de Shazer, 1988, p. 5). The miracle question elicits descriptions of specific and concrete behaviors. While addressing the miracle question, the student feels as if he or she is viewing him or herself in a movie and is describing each frame. After the initial question, the Behavioral Health Provider should follow up with questions that highlight the ways in which the student is behaving differently in the hypothetical situation than she or he is acting in the real world.

Getting the most out of this miracle question can take time, anywhere from a few minutes to an hour to detail the specifics of the situation. Once the differences between the current problem and the miracle solution are discussed, the next step is to try to find times when these differences are occurring in the here-and-now, at least in a small way.

Positive Feedback

With a focus on success and creating change in small steps, Behavioral Health Providers using SFBT techniques apply a generous portion of positive reinforcement through "cheerleading" and compliments (Walter & Peller, 1992). The compliments must be effective and the supportive statements must be sincere. "Cheerleading" is used to provide support for positive behaviors the student currently displays or for changes he or she uses to meet the goal. Walter and Peller (1992, p. 108) suggested two possible questions and a statement of praise to
assist in the process: 1. "How did you decide to do that?" 2. "How do you explain that?" 3. "That is really great!" By using the questions, the Behavioral Health Provider is asking the student to reflect on his or her actions in a purposeful light. One should remember that the delivery must be sincere. The compliment is a companion to cheerleading. It is a statement of praise or support focused on the student’s solution or goal. While everyone gives compliments on a regular basis, the compliments in SFBT serve several purposes in the process of change. Walter and Peller (1992) noted that compliments provide a positive climate, highlight the actions the student has already undertaken to reach a solution, alleviate student fears that the Behavioral Health Provider will pass judgment on them, and diffuse concerns about change.

Solution-Focused Brief Therapy in Schools

Solution-Focused Brief Therapy is a promising and useful approach in working with students at risk of academic and behavioral difficulties (Bond et al., 2013; Kim & Franklin, 2009). In several quasi-experimental designs, several researchers found statistically significant positive outcomes (LaFountain & Garner, 1996; Springer, Lynch, & Rubin, 2000). LaFountain and Garner (1996) investigated the impact of solution-focused groups on school age children and practitioners. They found significant between-group differences on three subscales of the Index of Personality Characteristics (Nonacademic, Perception, and Acting In), suggesting that the experimental group had higher self-esteem, more positive attitudes and feelings about themselves, and more appropriate ways of coping with emotions. Springer et al. (2000) determined that children receiving SFBT made significant pre- and posttreatment improvement on the Hare Self-Esteem Scale, whereas scores for those receiving no treatment were unchanged. SFBT is increasingly used in schools due to its flexibility, brevity, and efficacy (Murphy, 2008; Kim & Franklin, 2009). Having a theoretically sound, effective and efficient clinical intervention...
model is critical to successful school counseling programs, so identifying these models is imperative. This model is particularly well-suited to work in schools due to the high caseloads of most school counselors and the related need to respond to a variety of student situations efficiently and promptly.

Mental Health Providers are faced with these challenges and many others in schools similar to Kellman Elementary that are located in underserved communities. In Communities filled with violence, trauma, crime, a lack of resources, etc. schools are often looking for ways to support students to ensure their academic success. SFBT's positive focus and strength-based approach align with school counseling program models and educational outcomes.

Bond et al. (2013) conducted a metaanalysis of SFBT in multiple settings. This review focused on 38 qualitative and quantitative research articles that met standards for best evidence. Bond et al. detailed that SFBT shows promise for the solution-focused interventions in schools and recommended that future research is done to further explore the effectiveness of SFBT.

Bond noted that of the 38 studies that met the standard of “best evidence,” eight studies demonstrated that SFBT outcomes were better than the treatment provided in control groups which usually used “treatment as usual”, four resulted in no evidence of difference. The research suggests SFBT has generally positive results for children and youth who have internalizing behaviors, such as anxiety and depression, and most of the studies with high methodological quality were in this domain. Findings were complicated by the fact that many of the interventions used SFBT in combination with other practices, such as academic support, coaching, and empowerment training. For externalizing behaviors, such as aggression and social skills difficulties, the outcomes were strongest for SFBT interventions when the intervention occurred in schools and included teachers, when families were involved, and when used with younger
children. As with internalizing behaviors, several studies about externalizing behaviors combined SFBT with other practices, such as academic support and social skills training, with generally positive outcomes.

There are critiques of SFBT. Franklin (2001) suggested from the results of their single-case study that the SFBT intervention might be more effective in a school if the teachers and staff were trained in the model. These authors stated their belief that in order to maximize the model's effectiveness in a school setting, the entire school culture, norms, and practices would need to change and follow the strengths and empowerment orientation of the solution-focused model. This is consistent with research demonstrating that multicomponent interventions that work to change the school climate as well as teacher and parent interactions with the child are useful in school settings (Rones & Hoagwood, 2000).

Advantages of SFBT in Schools.

Some of the advantages that have been reported of utilizing SFBT in schools include; the model is flexible and easily utilized in school settings, more time is spent focusing on the student's strengths, claiming to yield rapid and enduring change, and a high degree of client satisfaction (Berg & Steiner, 2003). A key part of SFBT is to assist students with identifying their strengths in order to make them more evident to them as well as the adults in their lives. Identification of these strengths forms the basis of each child's unique solutions to their problems and helps to develop resilience (Berg & Steiner, 2003).

Disadvantages of SFBT in Schools.

There have been some reported disadvantages to utilizing SFBT. SFBT's quick, goal-oriented nature may not allow therapists the necessary time to empathize with what students in treatment are experiencing. As such, those in therapy may feel misunderstood if the
therapist is not meeting them on their emotional level. Another concern is the way SFBT seems to simply discard or ignore information deemed important by other treatment modalities (Sklare, 2005). For example, in this type of therapy a relationship between the adverse issues students face and the changes necessary to foster improvement is not assumed, and any underlying reasons for maladaptive thoughts and/or behaviors are not explored in a typical SFBT session. Individuals wishing to explore these reasons may find it more helpful to seek a type of therapy that addresses these concerns, though they may do so while also receiving SFBT (Sklare, 2005). SFBT discourages speculating about why symptoms arise, avoids discussion of the 'problem' (Brown & Brown, 2002: 64) and encourages solution talk.

Piercy, Lipchik, and Kiser (2000) state using SFBT with clients who have chronic disorders would be naïve and even harmful. They stressed some clients need to explore the past; thus, ignoring the past is neglecting the client’s history and can raise some ethical as well as clinical concerns. Stalker et al. alleged SFBT de-emphasizes affective factors, which they feel are vital to a client’s well-being. Piercy et al. (2000) echoed this sentiment and stated “solution-focused Behavioral Health Provider need to know how to acknowledge, join with, and respond to client emotions as well as thoughts and actions” (p. 26). These authors believed clients tend not to come back for future sessions if counselors focus only on solutions instead of listening to what clients try to tell them. The researcher recognizes these concerns and as a result, participants in need of more intensive or comprehensive services would be referred to appropriate outpatient mental health services.

Chapter Summary

This summary of SFBT outcome studies with children and youth reiterates the challenges of identifying effective treatment modalities as well as the lack of existing empirical research. As
with most outcomes studies of therapeutic approaches, there were very few studies that met the
criterion for empirical quantitative or qualitative research. Many studies used SFBT in
conjunction with other practices, confounding any outcomes, and the impact of SFBT varied
widely depending on the context and presenting issue of the youth involved. The outcomes
studied, as well as the measurements for those outcomes were varied, making comparisons
challenging. In Chapter 3, I will detail the research methodology to be used in this research
study.
Chapter 3. Research Methodology

This chapter will detail the methodology I used to determine whether or not students' behaviors differed pre and post SFBT. I will explain how the necessary data and information to address the research objectives and questions was collected, presented and analyzed. Some of the reasons and justifications for the research design research instruments, data sources, data collection techniques, data presentation techniques and analytical techniques to be used will also be given.

Participants

A letter of approval to collect secondary data (Appendix A) was provided from the Executive Director of I AM ABLE. The data was collected from assessments that were administered by Behavioral Health Providers at I AM Able to students who had been referred due to displaying adverse behaviors (uncontrollable anger, cheating, not paying attention in class, expressing sadness, hitting peers, etc.) during the academic school year 2017-2018. These assessments were gathered solely from students who had completed both a pre and post BRIC. All 23 students attended Joseph Kellman Elementary School. Students were seen once a week for an average of 13 sessions by the same Behavioral Health Provider each session.

Kellman Elementary is a Chicago Public School with 335 students in attendance, in grades PK-8. Joseph Kellman Elementary is located in the Chicago neighborhood of North Lawndale, (an adverse environment similar to those described in chapter 1). Secondary data was collected for the purposes of determining if students' behaviors, as measured by the BRIC, differ significantly based upon participation in SFBT.

Selection of sample.

A convenience sample is one of the main types of non-probability sampling methods. A convenience sample is made up of people who are easy to reach (Dudovskiy, 2012). The
Executive Director of I AM ABLE consented to the gathering and empirical assessment of secondary data in order to assess, strengthen and improve current programmatic goals. Students were referred/identified by staff (teachers, school counselors, principals) as needing therapeutic services in hopes of decreasing identified adverse behaviors, (cheating, getting very upset, hitting others, etc.) within the classroom setting (see BRIC assessment). The initial sample size was 25 and then reduced to 23 students after some date was found to be unusable.

Size, demographics, and variables.

I was given access to pre and post BRIC assessments from 25 boys and girls who attended Joseph Kellman Elementary School during the academic year 2017-2018. Kellman Elementary is a Chicago Public School with 335 students in attendance, in grades PK-8. Demographics and variables will be detailed in chapter 4.

Apparatus/Instrument/Materials

Behavioral Health Providers who work with children are continually confronted with a need for short, reliable, easy-to-administer measures that apply to a broad range of issues. It is important that any measures used to evaluate a child's behavior be valid and reliable. The BRIC is the assessment used to measure students' behaviors (see Appendix B).

Students' behaviors were measured both pre and post using the BRIC. The BRIC is a 13-item summated category scale that provides a measure of students' behavior problems. The BRIC is not a mental health assessment/questionnaire. It measures only the degree of a behavior problem (Hudson, 1982). Of the 13 items on the BRIC, 3 randomly placed items (items 1, 6, and 10) indicate a behavioral strength of the respondent (Stiffman, Orme, Eans, Feldman, & Keeney). These three items are not seen as adverse behaviors. These items are not calculated in the behavior problem score; only the 10 problem-oriented items are scored. The mean scores of
these 10 items was determined and listed in chapter 4. The 10 items are as follows; 1) Hide his/her thoughts from others 2) Say or do really strange things 3) Not pay attention when he/she should 4) Quit a job or task without finishing it 5) Hit, push, or hurt someone 6) Get very upset 7) Feel sick 8) Cheat 9) Lose his/her temper and 10) Get along poorly with other people. The three strength oriented items include; 1) Feel happy or relaxed 2) Get along well with other people and 3) Compliment or help someone. These items are embedded in the BRIC so that the respondents are not confronted solely with a list of “undesirable” behaviors and to discern evidence of extreme responses on the part of respondents.

Although the BRIC is valid and reliable in measuring students’ behaviors both pre and post SFBT, it does not measure or assess the potential impact of trauma on students’ behaviors. Additional trauma assessments will be recommended in chapter 5.

**Validity and reliability.**

The BRIC was evaluated for validity through its use with more than 600 children who participated in a field experiment known as the GAIN (Group Activities for Individual Needs) Program. The participants included both referred and non-referred children. The referred children's behavior also was evaluated both before and after group treatment by their parents or guardians (n = 183), by their teachers (n = 198), by group leaders (n = 28), and by nonparticipant observers (n = 13). The resultant scores then provided data to determine the internal consistency reliability of the BRIC (Stiffman, 1984). Repeated-measures reliability is frequently considered critical to any program that attempts to measure change overtime (Kerlinger, 1973). Each group of respondents that were asked to complete the BRIC, were asked to do so on a test-retest basis. Group leaders (n=11) and observers (n=6) from the second year’s cohort participated in two test-retest periods. They were asked to rate the children in their groups (n=155 and n=84,
respectively) twice within 1 week, both at the end of a 4-week baseline period and at the end of treatment (approximately 25 weeks later). Repeated-measures reliability from all respondents consistently demonstrated a level that indicates the BRIC is an appropriate measure of behavioral change. The results show that the BRIC is both valid and reliable for measuring students' behaviors.

Development of the BRIC.

Many brief instruments require 15-30 minutes to complete. Although this length is short for detailed behavior profiles, it is difficult for frequent test-retest evaluations, is highly intrusive in treatment situations, and is time consuming for evaluations of groups or classes of children (a particularly critical issue for school and community evaluations). Consequently, there was a need for a brief, accurate instrument that was appropriate for evaluating children of widely differing ages, that is available in comparable form for multiple informants, and that applies to group and classroom settings. A review of the available literature revealed no instruments that met all the above criteria prior to the BRIC (Stiffman, 1984).

Research design rationale.

Quantitative research is the systematic empirical investigation of observable phenomenon via statistical, mathematical or computational techniques (Cronbach, 1971). The following support the rationale for the chosen methodology; archival, statistical data was gathered and examined utilizing standard descriptive and inferential procedures, the original data was gathered using a structured research instrument, (BRIC) the results are based on a convenience sample drawn from students at Kellman who were referred for help with behavioral issues. The research study can be replicated or repeated. There is a clearly defined research question to which
objective answers were sought. All aspects of the study were carefully designed before data was collected, and then the data was entered into SPSS for standard statistical analysis.

Invalidity.

Studies using existing data have threats such as the selection of the population to study, which data to collect, the quality of data gathered, and how variables were measured and recorded are all predetermined. Also, existing data may have been collected from a population that is not ideal, the measurement approach may not be what the investigator would prefer (certain behaviors), the quality of the data may be poor (frequent missing or incorrect values) and important measures be not have been recorded (Creswell, 2015).

All these factors can contribute to the main disadvantages of using existing data. The quality of the data I collected, was assessed prior to the secondary data being used which means the data was assessed for completeness and accuracy. Missing data can reduce the statistical power of a study and can produce biased estimates, leading to invalid conclusions (Creswell, 2015). If there was missing data due to the subject not answering any questions pre or posttest, that subject's assessment was removed completely. The original data was collected to determine the effectiveness of SFBT on students' behaviors. Since the purpose for which the data was collected is similar to the research I conducted, the data was useful, and I was be able to rely on it in my study.

Procedures.

Originally, Behavioral Health Providers at I AM ABLE used the BRIC as a tool to measure the effectiveness of SFBT on students' behaviors both pre and post implementation. I collected secondary data from these identified students, who had previously participated in SFBT and completed a pre and post BRIC assessment. My current research question was addressed
quickly and efficiently by utilizing secondary data. Secondary data analysis is the use of existing data to investigate research questions other than the main ones for which the data were originally gathered (Cohen, 1977). Making creative use of existing data is a fast and effective way for new researchers with limited resources to begin to answer important research questions, gain valuable experience in a research area, and sometimes have a publishable finding in a short time frame (Cohen, 1977). A research question that might otherwise require much time and money to research can sometimes be answered rapidly and inexpensively utilizing secondary data.

During the month of March 2019, I gathered secondary data (facility and service provided assessments and data) from an identified group of 25 students at Kellman Elementary School from I AM ABLE. These students had previously completed pre and post BRIC assessments during the academic school year 2017-2018. Students completed BRIC assessments in the School Counselor’s office in the presence of I AM ABLE’s Behavioral Health Providers.

Data analysis.

After collecting the data, I input the data into the Statistical Package for the Social Sciences (SPSS) system. This is a system that is widely used for statistical analysis (Cohen, 1977). Input (x) is representative of SFBT and output (y) is representative of students’ behaviors. SPSS was used to summarize and describe the data. The paired-sample t-test was used to analyze the data and test the hypotheses. The paired-samples t-test compares the means of two related groups to determine whether there is a statistically significant difference between the means (Cohen, 1977). The independent variable in this study is SFBT and the dependent variable is students’ behaviors.

All experiments examine variables. A variable is not only something that can be measured, but also something that can be manipulated and something that can be controlled. The
independent variable is a variable that is being manipulated in an experiment to observe its
effects on the dependent variable. The dependent variable is the event expected to change when
the independent variable is manipulated. In this study, I examined both the independent variable
(SFBT) as well as the dependent variable (scores on the BRIC). A narrative summary was
provided about the sample and the measures. A paired sampled t-test was conducted to determine
whether or not there was a difference or change in the means pre (means X 1) and post (means X
2) SFBT.

Limitations.

Possible limitations to the study could be the small sample size of 23 students (Creswell,
2015). SFBT may not be the highest level of care needed for students who have experienced
complex trauma. According to The National Child Traumatic Stress Network, complex trauma
describes both children's exposure to multiple traumatic events—often of an invasive,
interpersonal nature—and the wide-ranging, long-term effects of this exposure. These events are
severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can
disrupt many aspects of the child's development and the formation of a sense of self (Honberg,
2011). Since these events often occur with a caregiver, they interfere with the child's ability to
form a secure attachment. Many aspects of a child's healthy physical and mental development
rely on this primary source of safety and stability.

Chapter Summary

There are several factors that contribute to the main disadvantages of using existing data.
The quality of the data was assessed prior to the information being used. The data was assessed
for completeness and accuracy. The original data, (Collected by Behavioral Health Providers at I
AM ABLE) was collected to determine the effectiveness of SFBT on students' behaviors. Since
the purpose for which the data was collected is similar to the research conducted, it is likely the
data was useful and reliable in my study.

Chapter 4. Research Findings

Introduction

In this chapter, I will discuss the participant’s’ demographics, the descriptive statistics,
the results of the paired samples t-test, negative and positive findings, and the shortcomings in
the data. The research question for this study is:

Will students’ behaviors differ significantly, as measured by the BRIC, based upon participation
in SFBT?

H₀: Students’ behaviors, as measured by the BRIC, will not differ based upon participation in
SFBT.

H₁: Students’ behaviors, as measured by the BRIC, will differ based upon participation in SFBT.

The following participant demographics are listed in Table 1 below; gender, race, year in
school, and the number of sessions. Data was collected from 9 males and 16 African-American
females, 7 of whom were in grades K-3, 9 students in grades 4-6, and 6 in grades 7-8. The mean
number of sessions was 13 and the number of sessions ranged from 2-24.
Table 1

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>65</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>23</td>
<td>100%</td>
</tr>
<tr>
<td>Year in School</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kindergarten</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>First</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Second</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Third</td>
<td>5</td>
<td>22%</td>
</tr>
<tr>
<td>Fourth</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Fifth</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Sixth</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Seventh</td>
<td>2</td>
<td>9%</td>
</tr>
<tr>
<td>Eighth</td>
<td>7</td>
<td>30%</td>
</tr>
</tbody>
</table>

Results of Data Analysis

Two participants were found to have missing data, (did not answer any questions on BRIC) that would not lend to the analysis thereby resulting in a sample size of n=23. The remaining data from the 23 participants was entered into the SPSS. A reliability analysis refers to the fact that a scale should consistently reflect the construct it is measuring (Creswell, 2015). A reliability analysis for the ten variables in this study was conducted and an internal consistency coefficient of .77 was obtained. In statistics and research, internal consistency is typically a measure based on the correlations between different items on the same test. It measures whether several items that propose to measure the same general construct produce similar scores and an internal consistency coefficient of .70 or above is considered an acceptable measure (Creswell, 2015).
The mean, standard deviation, standard error and skewness for the pre and post test variables are reported in Table 2. Skewness is a statistic indicating the shape of a distribution wherein one tail of a frequency distribution is longer (or larger) than the other. A perfectly normal distribution has a skewness statistic of zero. A widely accepted guideline, (Leech, N.L., Barrett, K.C. & Morgan, G. A, 2005; Creswell, 2015) states that if the skewness is between plus one and minus one, the data can be assumed to be normally distributed. However, the t test is highly robust such that a skewness of more than plus/minus one (as seen below: pre/post feel sick, and pre/post cheat) may not change the results much (Creswell, 2015).

Descriptive statistics.

In Table 2, descriptive statistics are listed and include the mean of the 10 items on the BRIC, the standard deviation, standard error and skewness.
A paired samples t-test was used to summarize and describe the data. The paired samples t-test compares the means of two related groups to determine whether there is a
statistically significant difference between the means (Cohen, 1977). The independent variable in this study is Solution-Focused Brief Therapy and the dependent variable is students' behaviors.

A paired samples t-test (see Table 3) was performed in order to test the research question for this study: Will students' behaviors differ, as measured by the BRIC, based upon participation in SFBT?

Table 2

*Descriptive Statistics and t-test Results for BRIC*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Pretest M</th>
<th>Pretest SD</th>
<th>Posttest M</th>
<th>Posttest SD</th>
<th>n</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hide Thoughts</td>
<td>2.52</td>
<td>.25</td>
<td>2.2</td>
<td>.229</td>
<td>2</td>
<td>(-.325; .847)</td>
<td>.923</td>
<td>22</td>
<td>.183</td>
</tr>
<tr>
<td>Strange Things</td>
<td>2.57</td>
<td>.31</td>
<td>2.2</td>
<td>.290</td>
<td>2</td>
<td>(-.353; .962)</td>
<td>.960</td>
<td>22</td>
<td>.174</td>
</tr>
<tr>
<td>Not Pay Attention</td>
<td>3.40</td>
<td>.24</td>
<td>3.4</td>
<td>.234</td>
<td>2</td>
<td>(-.573; .399)</td>
<td>-.371</td>
<td>22</td>
<td>.357</td>
</tr>
<tr>
<td>Quit</td>
<td>2.96</td>
<td>.29</td>
<td>3.1</td>
<td>.297</td>
<td>2</td>
<td>(-.766; .419)</td>
<td>-.609</td>
<td>22</td>
<td>.274</td>
</tr>
<tr>
<td>Hit, Push, Hurt</td>
<td>2.17</td>
<td>.26</td>
<td>2.2</td>
<td>.253</td>
<td>2</td>
<td>(-.537; .363)</td>
<td>-.401</td>
<td>22</td>
<td>.341</td>
</tr>
<tr>
<td>Get Along Poorly</td>
<td>2.48</td>
<td>.30</td>
<td>2.7</td>
<td>.276</td>
<td>2</td>
<td>(-.785; .264)</td>
<td>-.103</td>
<td>22</td>
<td>.157</td>
</tr>
<tr>
<td>Get Very Upset</td>
<td>2.61</td>
<td>.30</td>
<td>2.2</td>
<td>.276</td>
<td>2</td>
<td>(-.056; .752)</td>
<td>1.79</td>
<td>22</td>
<td>.044*</td>
</tr>
<tr>
<td>Feel Sick</td>
<td>1.43</td>
<td>.16</td>
<td>1.3</td>
<td>.119</td>
<td>2</td>
<td>(-.302; .476)</td>
<td>.463</td>
<td>22</td>
<td>.324</td>
</tr>
<tr>
<td>Cheat</td>
<td>1.65</td>
<td>.17</td>
<td>1.3</td>
<td>.132</td>
<td>2</td>
<td>(.013; .683)</td>
<td>.215</td>
<td>22</td>
<td>.021*</td>
</tr>
<tr>
<td>Lose Temper</td>
<td>2.43</td>
<td>.36</td>
<td>2.3</td>
<td>.329</td>
<td>2</td>
<td>(.327; .588)</td>
<td>.591</td>
<td>22</td>
<td>.280</td>
</tr>
</tbody>
</table>

* p < .05.

As shown in Table 3, the one tailed paired samples t-test indicated that scores for getting very upset were on average significantly lower at posttest, $t_{(22)} = 1.79$, $p = .045$, $d = .37$; and that the
scores for cheating were also on average significantly lower at posttest, \( t(22) = 2.15, p=.021, d=.44 \). These differences are statistically significant, and they are typical or medium size effects (Cohen, 1988). None of the other variables demonstrated statistically significant pre-posttest differences on the paired samples t-test: Hide Thoughts \( t(22) = .923, p=.183 \); Strange Things \( t(22) = .960, p=.174 \); Not Pay Att \( t(22) = .371, p=.357 \); Quit \( t(22) = -.609, p=.274 \); Hit Push Hurt \( t(22) = -.401, p=.341 \); Get Along Poorly \( t(22) = -1.03, p=.157 \); feel Sick \( t(22) = .463, p=.324 \); and Lose Temper \( t(22) = .591, p=.280 \).

Negative and positive findings.

This study produced positive findings. A positive finding is knowledge that a variable definitely has a particular value (Creswell, 2015). As shown in Table 2, the paired sample t test indicated that scores for getting very upset were on average significantly lower at post test, \( +(22) = 1.79, p=.045, d=.37 \). The scores for cheating were also on average significantly lower at post test, \( t(22) = 2.15, p=.022, d=.44 \). These differences are statistically significant. If the p-value is less than or equal to the set significance level, the data is considered statistically significant. As a general rule, the significance level (or alpha) is commonly set to 0.05, meaning that the probability of observing the differences seen in your data by chance is just 5% (Creswell 2015).

Shortcomings in the data.

A larger sample size would help the study be more conducive to findings of significance. In other words, the larger the sample size, the more likely we are to find significance (Creswell, 2015). The data is also more likely to be conclusive with a larger sample size. Although SFBT has been proven to be effective in reducing adverse behaviors in students who are in grades PK-8, I would in the future be interested in research surrounding significant differences pre and post SFBT in students in each individual grade. I would also be interested in any research surrounding
significant differences in males versus females, African-American students versus White students, and students who attend schools in adverse communities versus those who do not. This study focused primarily on secondary data collected from 23 African-American, males and females, in grades K-8, attending school at Kellman Elementary which is located in the North Lawndale neighborhood on Chicago’s west side.

Chapter Summary

In this chapter we discussed the results of the data collected, the descriptive statistics, the results of the paired samples t-test, the negative and positive findings, and the shortcomings in the data. This study produced positive findings and there were two variables, (getting very upset and cheating) that showed a significant change pre and post implementation of SFBT.
Chapter 5. Conclusion

In this chapter, I will discuss the overall results of the study and the data collected, its relationship to prior research, limitations of the study and my implications for further research. Solution-Focused Brief Therapy, as measured by the BRIC, proved that SFBT is a promising model being utilized with students (in-school) in grades K-8. I will conclude with recommendations for practice and further studies.

Discussion

The current study represents promise regarding Solution-Focused Brief Therapy. To provide empirical evidence of SFBT’s usefulness, future research must utilize adequate sample sizes, comparison groups, more than one assessment tool by which to measure the significant change in students’ behaviors pre and post SFBT. The evidence herein shows that 2 out of 10 items had significant pre-post positive change.

Overall, studies have taken place using a wide variety of settings and populations. I would suggest a variety of settings within the school, if possible. These studies will enhance future studies for more rigorously controlled research that can provide conclusive evidence of SFBT’s usefulness. Ultimately, SFBT is a method that warrants further research, but because significant difference was seen for at least two of the variables, SFBT proves to be a promising therapeutic model for decreasing the items, getting upset and cheating. The additional behaviors that were named on the BRIC that did not show significant difference are; hide thoughts, say or do really strange things, not pay attention, quit a task before finishing it, hit, push, or hurt someone, get along poorly with others, feel sick, and lose his/her temper.
Theoretical

The theory states that children may develop behavioral health issues as a result of exposure to adverse experiences. These behavioral health issues present obstacles to good school adjustment and academic performance. Furthermore, these behavioral health issues can be measured using the BRIC and can be treated using SFBT. Testing of the hypothesis in the current study supports this theory for some behaviors.

Practical

In future studies, I would increase the number of sessions the students received, ensure that each session utilized the maximum 30 minutes amount of time recommended for SFBT, and use more than one measure of behavioral health issues. I would also use a larger sample size, while adding a comparison group to add more rigor to the analysis. As a Licensed Professional Counselor who has utilized SFBT while working with students in a school setting, I agree with all of the previous stated evidence that supports positive findings related to SFBT as a therapeutic intervention for child behavior problems.

Relationship to Prior Research

LaFountain and Garner (1996) investigated the impact of SFBT on school-age children. They found significance between differences on three subscales of the Index of Personality Characteristics, suggesting that the experimental group had higher self-esteem, more positive attitudes and feelings about themselves, and more appropriate ways of coping with emotions. Compared to my study, their studies had more variables that showed a significance in change pre and post SFBT. These researchers also utilized a different assessment tool than I AM ABLE to measure students' behaviors pre and post SFBT. In the future, I would consider using the BRIC and another empirically studied assessment that measures similar behaviors as the BRIC for pre
and post SFBT. This would help to determine which of the two measures would be the strongest or show the greatest level of significance.

Bond (2013) also determined it was important to combine individual and group-level intervention with organizational interventions in order to increase positive outcomes. The multi-component interventions that work to change the school climate as well as teacher and parent interactions with the child are useful in school settings (Rones & Hoagwood, 2000). Spencer, Ritchie, Lewis and Dillon (2003) had similar findings. They found that outcomes for externalizing behaviors, such as aggression and social skill difficulties, were strongest for SFBT interventions when the intervention occurred at the school-level and included teachers and families. In order to maximize the SFBT’s effectiveness, Franklin suggested that teachers and staff be trained in the model. He believed that in order to maximize the model’s effectiveness in a school setting, the entire school culture, norms, and practices would need to change. I would be interested in including teachers and families in future studies. If the teachers and families, in addition to the Behavioral Health Provider are also implementing SFBT, this could possibly increase the significance in difference pre and post SFBT. I would meet with teachers and caregivers of identified students to discuss the students’ score on the BRIC pre implementation of the SFBT model, educate them in the interventions of SFBT and how they could also help students apply these interventions, and then meet a final time with teachers and caregivers post SFBT implementation to not only discuss empirical data but anecdotal findings as well.

Compared to the previously mentioned researchers’ findings surrounding SFBT and including teachers and families, my study focused only on the Behavioral Health Providers implementing SFBT with the identified students. Their findings showed strong outcomes in the areas of aggression and social skills. My study showed a decrease in students getting upset post
SFBT which could correlate with aggression. Some of the other items on the BRIC, could also correlate with aggression, (getting along poorly with others, losing his/her temper, hitting, pushing, and hurting someone) and if so, these other items could also show significant outcomes as measured by the BRIC, in future studies designed as suggested above.

Kim and Franklin (2009) examined the most rigorous outcome studies on SFBT conducted in schools. Their review found mixed results but SFBT did show promise as a useful approach in working with at-risk students in a school setting, specifically helping students reduce the intensity of their negative feelings, manage their conduct problems, and externalizing behavioral problems. Their findings were similar to my research findings in that there was a significant change seen in students who were very upset (negative feelings) and students who cheated (external behavioral problems). This means students who scored high in the areas of getting very upset and cheating pre SFBT, improved these behaviors post implementation of SFBT which means that the model was proven to be effective in reducing two out of the ten adverse behaviors.

Bond (2013) found that larger sample sizes and improved research designs were needed to further substantiate findings and to build an evidence-based SFBT for education. This study had a sample size of 23. The sample size was small due to convenience sampling provided by Kellman Elementary School who only provided SFBT services to 25 identified students during academic year 2017-2018. As previously stated, two of the students did not provide any responses for pre/post BRIC assessments, which caused their data to not be utilized. Bond also determined that the majority of the studies did not use random assignment because schools do not permit random sampling (2013). The students in this study were not randomly assigned which represents one of the limitations of the study.
Limitations of the Study

I consider the following to be limitations to my study; a small sample size (23), there was only one assessment tool used to gather data (BRIC) that may or may not be the best assessment tool for this particular study and/or this particular population, SFBT was the only treatment approach used and may or may not have been the best treatment approach for the behaviors listed on the BRIC, since the data collected was secondary, there was no way to know if the outcomes of the study might have been different if the amount of sessions were increased and/or extended.

Implications for Further Research

According to the research previously mentioned in chapter one surrounding trauma that exist in communities such as North Lawndale, I would suggest that a trauma screening or assessment be utilized with identified students. A Trauma-Informed Mental Health Assessment refers to a process that includes a clinical interview, standardized measures, and/or behavioral observations designed to gather an in-depth understanding of the nature, timing, and severity of the traumatic events, the effects of those events, current trauma-related symptoms, and functional impairment (Nuyan, 2018). Clinicians use the assessment to understand a child’s trauma history and symptom profile; to determine whether a child is developmentally on target in the social, emotional, and behavioral domains; to inform case conceptualization and drive treatment planning; and to monitor progress over time.

Implications for Policy and Practice

Based on the findings of this study, the following suggestions may or may not have an impact on outcomes. It is recognized that many suggestions will require additional resources. Mental Health Providers working with students in traumatized communities should consider conducting a Mental Health Trauma Assessment. This assessment would provide data that would
support the Mental Health Provider in utilizing the best form of therapy for the students’ presenting symptoms. Mental Health Providers should also consider training parents and caregivers along with school staff in SFBT. They would not need to actually apply the therapy but should be aware of the goals of SFBT and ways they can support the Mental Health Providers both in and outside of the school setting. Universities should consider incorporating a course(s) about what trauma is and how to respond to students within the classroom setting who have experienced trauma.

In the future, I would not utilize secondary data in order to have more control over the treatment approach used. I used secondary data collected from I AM ABLE in order to help support the improvement of their current programming and services being provided to identified students within the school setting. In the future, I would prefer to collect my own data in order to have more control over the data gathered and the assessment of outcomes. Since there were 2 out of 10 items in my study that showed significant difference pre and post SFBT, in the future, I would focus on the variables in my study that did not show significance in change by adding other clinical interventions/approaches, and empirical assessment tools to research how SFBT and the BRIC compare through rigorous studies. One such therapeutic intervention would be Cognitive Behavioral Therapy. Cognitive Behavioral Therapy (CBT) is an approach with a strong research base that is easy to implement in a school setting. This approach could not be used with students under the age of 8 (Karp, 2012). A lot of the concepts involved in CBT treatment are beyond the cognitive skills of children younger than age 8. They aren’t ready yet to make the connection between their thoughts, feelings, and actions, much less make a plan for how to change any component (Karp, 2012).
I would also suggest a larger sample size for future studies. LaFountain and Garner (1996) investigated the impact of solution-focused groups on school age children (N= 311). They found significant between-group differences on three subscales of the Index of Personality Characteristics (Nonacademic, Perception, and Acting In), suggesting that the experimental group had higher self-esteem, more positive attitudes and feelings about themselves, and more appropriate ways of coping with emotions. Springer et al. (2000) determined that children receiving SFBT made significant pre- and posttreatment improvement on the Hare Self-Esteem Scale, whereas scores for those receiving no treatment were unchanged. I would consider using this scale, amongst others in future studies.

There are two ways to look at the differences between subjects in a research study, between-group and within-group differences. When data shows differences among subjects within the same group, this is called within-group differences (Creswell, 2015). My data showed that each of the 23 students in my study had different outcomes pre and post SFBT. In the future, I would consider doing research around students in each individual grade instead of getting a mean score for all students in grades K-8. I would be interested in determining if the difference in grade level (age) had an impact on significance of difference pre and post SFBT.

Between-group differences produce data that show two or more groups are different (Creswell, 2015). In the future, I would consider conducting more research around an experimental group who received SFBT and a control or comparison group that did not receive the intervention. I would also be interested in studying a male group and a female group, white students versus black students, students living in traumatized communities who are of a low socio-economic status residing in communities such as North Lawndale versus students who are of a higher socio-economic status residing in thriving communities that are not impoverished.
The annual median earnings for residents in North Lawndale is $22,383.00 (North Lawndale, n.d.). According to an article published in the American Counseling Association, when providing services to students of a low socio-economic status, counselors may find it helpful to use a strengths-based therapeutic approach. The evidence-based practice of SFBT zeros in on the therapeutic relationship and the clinician's way of being. In this relationship, there is an acknowledgment of reality but also an emphasis on solution-focused thought and reframing (Murphy, 2008). A possible difference in these groups may or may not have an impact on significance seen pre and post SFBT.

I would also consider conducting qualitative research utilizing Grounded theory. Grounded theory is a type of qualitative research methodology that allows theory/theories to emerge from the data that is collected via observation and interviews (Creswell, 2015). Grounded theory research follows a systematic yet flexible process to collect data, code the data, make connections and see what theory/theories are generated or are built from the data. There may be a theory that arises from the collection of data that would possibly support the need for trauma counseling within the school setting.

Chapter Summary

The students at Kellman attend school in an impoverished, traumatized community. Trauma can have a negative impact on students' behaviors and their academic performance (Nuyan, 2018). The impact of trauma on students' behaviors should be researched in the future. This will help to determine best practices for providing mental health services to students who have experienced and have been impacted by some form of trauma.

There is significant research surrounding the effectiveness of SFBT and students' adverse behaviors. In my study, a significant difference was seen in students' behaviors, (cheating and
getting very upset) as measured by the BRIC pre and post implementation of SFBT in this study. This study proved that SFBT is not only effective with students but with students in a school setting. There were a few limitations to the study which support the need for future research to be conducted.
References


Piercy, F., Lipchik, E., & Kiser, D. (2000). Miller and De Shazer’s article on emotions in


## Appendix B

### Behavior Rating Index for Children

**IN GENERAL, HOW OFTEN DOES YOUR CHILD:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Rarely never</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A good part of the time</th>
<th>Most or all of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hide his/her thoughts from other people?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Say or do things which are not true</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Not pay attention when he/she should?</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Get along well with other people?</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Socially withdrawn</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Get along poorly with other people?</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Compliment or help someone?</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Tell lies or cheat</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Steal lottery money</td>
<td>Rarely never</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>