12-2016

Evaluating practicum student's' therapeutic effectiveness using solution focused brief therapy with Mexican American clients: A single case design

Krystle L. Ortega
The University of Texas Rio Grande Valley

EVALUATING PRACTICUM STUDENT'S' THERAPEUTIC EFFECTIVENESS USING SOLUTION FOCUSED BRIEF THERAPY WITH MEXICAN AMERICAN CLIENTS: A SINGLE CASE DESIGN

A Thesis

by

KRYSTLE L. ORTEGA

Submitted to the Graduate College of
The University of Texas Rio Grande Valley
In partial fulfillment of the requirements for the degree of

MASTER OF EDUCATION

December 2016

Major Subject: Counseling and Guidance

EVALUATING PRACTICUM STUDENT'S' THERAPEUTIC EFFECTIVENESS

USING SOLUTION FOCUSED BRIEF THERAPY

WITH MEXICAN AMERICAN CLIENTS:

A SINGLE CASE DESIGN

A Thesis
by
KRYSTLE L. ORTEGA

COMMITTEE MEMBERS

Dr. James Ikonomopoulos
Chair of Committee

Dr. Lionel Javier Cavazos Vela
Committee Member

Dr. James Whittenberg
Committee Member

Dr. Bernardo de la Garza
Committee Member

December 2016

ABSTRACT

Ortega, Krystle L., Evaluating Practicum Student's' Therapeutic Effectiveness Using Solution Focused Brief Therapy with Mexican American Clients: A Single Case Design. Master of Education (M.Ed.), December, 2016, 39 pp., 3 tables, 2 figures, references, 56 titles.

The purpose of this study is to examine the effectiveness of a practicum counseling experience on client therapeutic outcomes using Solution Focused Brief Therapy with Mexican American clients. We implemented a small series (N = 3) single-case research design to assess the effectiveness of SFBT for increasing hope and decreasing clinical symptoms. Clients' clinical areas of functioning and clinically significant change will be evaluated using the Outcome Questionnaire -45.2 whereas hope will be assessed using The Trait Hope Scale. The results of this study will ultimately help researchers in counseling education, counselors, supervisors, and students by providing an outcome measure of practicum student therapeutic effects with Mexican American clients using SFBT.

Keywords: practicum, counselor education, solution focused brief therapy, Mexican-American, single case research designs

DEDICATION

The completion of my master's degree would have not been promising without the love and support of my family. My mother, Blanca, my father, Xavier, and my son, Nico, have wholeheartedly inspired and motivated me to accomplish a degree in counseling. Without them, this would not have been imaginable. Thank you so much for all of your patience, understanding, and unconditional love. I love you all dearly and dedicate this accomplishment to you.

ACKNOWLEDGMENTS

I am forever grateful to my chair, Dr. Ikonomopoulos, and committee members: Dr. Lionel Javier Cavazos Vela, Dr. James Whittenberg, and Dr. Bernardo de la Garza for all of their mentoring and encouragement. From research design, data processing, and manuscript editing, they have helped ensure the quality of my thesis and educational attainment. I am thankful for their sustained assistance, guidance, and patience during this journey. I would also like to thank my colleagues within my program who have motivated and praised my efforts throughout the years. This study and degree would not be possible without their continued support.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

CHAPTER I

INTRODUCTION

The Hispanic population is one of the fastest growing groups in the United States with individuals of Mexican decent accounting for the largest sub-group (Colby & Ortman, 2014; Ennis, Ríos-Vargas, & Albert, 2011; Zamarripa, 2009). The Mexican American population is labeled *at risk* due to their high poverty rates, health risk behaviors, low educational attainment, and lesser access to health care (Dunn & O'Brien, 2009; Morales, Lara, Kington, Valdez, & Escarce, 2002; Munoz- Laboy et al., 2015). Consequently, Mexican Americans are at greater risks for depressive symptoms, mental health impairment, suicide ideation and attempts, and hopeless feelings (Centers for Disease Control and Prevention, 2011; Wagstaff & Polo, 2012). When we turn our focus to counseling, Mexican Americans tend to underutilize mental health services, discontinue treatment prematurely, and receive poor quality of services (Hunt et al., 2013). These factors may be due to economic or structural barrier and not the unwillingness to enter counseling (Zamarripa, 2009). As a result, Mexican Americans continue to be one of the most vulnerable populations in the United States whose mental health needs are often unaddressed (Gonzalez Suitt, Frankin, & Kim, 2016). It is important to investigate an intervention that may be useful in enhancing mental health among a group whose experiences and needs are often marginalized in mainstream society (Zamarripa, 2016).

Statement of the Problem

Mental health literature investigating solution focused brief therapy has increased over the last two decades (Zamarripa, 2009). Seemingly, the upsurge of the Latino population has provided an increased consideration for research. However, there remains a dearth of literature linking the two motivations for study, specifically with Mexican Americans. A meta- analysis examining SFBT with the Latino population revealed two main reasons that are the basis for our study: the lack of knowledge regarding the effectiveness of SFBT with Latino populations and the prospect to enhance the quality of services received by disadvantaged populations (Gonzalez Suitt, Frankin, & Kim, 2016).

Magyar-Moe, Owens, and Conoley (2015) investigated SFBT and proposes that this intervention has been applied with many different countries, with diverse racial and ethnic groups, and across cultures. Correspondingly, Schmit, Schmit, and Lenz (2016) conducted a meta- analysis and found 67% of studies available were from outside the United States and piloted around the world. However, these numbers leave a small percentage of studies involving Americans, a reduced number with Latinos, and a minor number with individuals of Mexican decent. In fact, Zamarripa (2009) cited that SFBT with Latinos and Mexican Americans is a weakness in research and recommends further investigations. For this reason, our current study aims to fill the gap regarding the effectiveness of SFBT with culturally-diverse populations (Bermudez & Mancini, 2013; Dunn & O'Brien, 2009; Owens & Conoley, 2015; Magyar-Moeto, 2015; Schmit et al., 2016; Vela et al., 2014) and include clients who identify as Mexican American as three-quarters of the Hispanic or Latino population is of Mexican decent (Ennis, Ríos-Vargas, & Albert, 2011).

Statement of the Purpose

Suldo and Shaffer (2008) argued that using a dual-factor model of psychological functioning with indicators of wellness (e.g. hope) and illness (e.g. clinical symptoms) allows researchers and practitioners to measure and understand mental health. Viewing mental health as only psychopathology excludes important positive areas of mental health such as life satisfaction and hope. Additionally, there is a request for researchers to utilize a strength-based approach in a culturally sensitive manner (Bermudez & Mancini, 2013, Cavazos Vela et al., 2014, Dunn & O'Brien, 2009, & Magyar-Moeto, 2015). Therefore, in this study, we examine changes in psychological health using the Outcome Questionnaire -45.2 and The Trait Hope Scale by providing Solution-Focused Brief Therapy with Mexican American adults. Our study aims to identify whether SFBT provides clinically significant change in client outcomes as Gingerich and Eisengart (2000) revealed that only one study investigating SFBT has reported clinically significant change in client outcomes.

Solution focused brief therapy was selected for several reasons. Some reasons that are important for beginning counselors. SFBT has the potential to serve as a training model for students in community or mental health counseling (Hatchett, 2011). Solution focused brief therapy's focus on developing well-defined goals, the ability to highlight client strengths by exception questions and compliments which facilitates rapport with clients, the use of scaling questions to serve as tracking goal progression and client change, and that it's respect to cultural backgrounds can aid students in a brief and empirically supported therapy as part of their training experience (Zamarripa, 2009). Secondly, researchers found SFBT to be an efficacious treatment; nonetheless, it is recommended further investigating SFBT to be considered for evidence based practice (Kim, 2008) Furthermore, little has been written about the experiences of solution

focused brief therapy with the Latino community. For this purpose, we examine solution-focused brief therapy with Mexican American adults seeking treatment in a university counseling clinic and provide counselors with empirical support for utilizing SFBT.

In the present study, we implement a single case research design to assess treatment effects on increasing hope and decreasing clinical symptoms using solution-focused brief therapy. The rationale for using a single case research design (SCRD) is to explore the therapeutic effects of an intervention with Mexican Americans. Lenz (2015) described how researchers and practitioners can use SCRDs to evaluate treatment outcomes. SCRDs are ideal for practicing counselors for the following reasons: flexibility and responsiveness, small sample size, ease of data analysis, self-control, and type of data yielded from analyses. At the community counseling center where we recruited participants, a SCRD was more feasible than a between-groups design given the small sample size and the potential to examine the efficacy of an intervention with a diverse population (e.g., Mexican Americans). Therefore, we implemented a SCRD (Lenz, Speciale, & Aguilar, 2012) to identify and explore trends of changes in hope and clinical symptoms as a result of participation in SFBT.

Research Questions

Based on previous research, we will explore the following research question:

1) To what extent is solution focused brief therapy effective for increasing hope on the Trait Hope Scale among Mexican American clients?
2) To what extent is solution focused brief therapy effective for decreasing clinically significant psychological symptoms on scores of the Outcome Questionnaire -45.2 among Mexican American clients?

3) What graphical representations will determine whether meaningful change has been distinguished between baseline and treatment phases?
4) What effect sizes by non-overlap data analysis procedures are indicative of effective treatment?

Based on previous literature representing solution focused brief therapy to be efficacious with diverse populations, we hypothesize that solution focused brief therapy will support in increasing feelings of hope and decreasing clinical symptoms among Mexican American clients. Moreover, we hypothesize that meaningful change will occur using an empirically supported intervention, solution-focused brief therapy, with indicative treatment effects.

CHAPTER II

REVIEW OF LITERATURE

The Hispanic population is one of the fastest growing groups in the United States, accounting for 56% growth in the last decade (Ennis, Ríos-Vargas, & Albert, 2011). Of this upsurge, Mexican-Americans accounted for three-quarters of the 15.2 million increases and are projected to double by the year 2060 (Colby & Ortman, 2014). Most literature with Hispanic groups labels Hispanics at-risk, focusing on challenges and barriers (Dunn & O'Brien, 2009) such as high poverty rates, health risk behaviors, low educational attainment, and less access to health care (Morales, Lara, Kington, Valdez, & Escarce, 2002). Additionally, the Latino population has underutilized mental health services, discontinued treatment prematurely, and received poor quality of services even after controlling for mental health needs and health insurance status (Hunt et al., 2013). Consequently, Mexican Americans may remain one of the most vulnerable groups in the United States (Gonzalez Suitt et al., 2016). Because of such stressors, researchers have examined and identified a number of internalizing and externalizing symptoms that represent Mexican Americans' mental health experiences.

Mexican Americans are at greater risks for depressive symptoms, mental health impairment, suicide ideation and attempts, and hopeless feelings (Centers for Disease Control and Prevention, 2011; Wagstaff & Polo, 2012). Researchers also have detected that Mexican American youth have higher levels of psychosomatic problems and anxiety symptoms as they

emerge into adulthood (Glover, Pumariega, Holzer, Wise, & Rodriguez, 1999; Pina & Silverman, 2004). According to Munoz- Laboy et al. (2015), minority stressors such as discrimination, job loss, and lack of family support were the strongest predictors of anxiety and depression. Moreover, familial factors caused the greatest burden for negative mental health outcomes when compared to other factors.

To understand Latino mental health functioning, it is important to understand the cultural importance of family dynamics or familismo (Ayon, Marsigliai, & Bermudez-Parsai, 2010; Calzada, Tamis,-LeMonda, and Yoshikawa, 2013; Priest & Denton, 2012). Calzada, Tamis,-LeMonda, and Yoshikawa (2013) highlighted that although family support can positively impact mental health, family can become a source of conflict and stress, which might result in poor mental health. Priest and Denton (2012) also found that family cohesion and family discord were associated with anxiety. Additionally, when there is indication of a 12-month prevalence of family discord, there was an association with almost all anxiety disorders in Latinos (Calzada, Tamis-LeMonda, & Yoshikawa, 2013). Given that Mexican Americans might be at greater risks for psychopathology and their mental health needs are often unaddressed, further evaluation of counseling practices for this population is necessary. The dearth of literature available for this population reinforces the need to examine the effectiveness of interventions with specific cultural groups.

Some researchers have explored the utility of interventions with Mexican American populations. Researchers indicated that Cognitive Behavior Therapy can be effective for Latinos who are primarily English-speaking and likely more acculturated (Chavira et al., 2014). Narrative Therapy presented to be efficacious for incarcerated Mexican American youth struggling with mental health symptoms (Ikonomopoulous, Smith, & Schmidt, 2015). Schmit et

al. (2016) found 26 empirical studies examining the effectiveness of solution-focused brief therapy for treating internalizing disorders such as depression and anxiety. Their investigation of SFBT was an overall moderately successful treatment for decreasing internalizing symptoms in youth and adults when compared to alternative treatment or no treatment at all. Researchers noticed adults to have 5 times larger treatment effects when compared to youth and adolescents. A possible explanation is that SFBT may require a level of maturity or higher level of cognitive development by the client to integrate concepts and techniques of SFBT. Furthermore, researchers concluded that the effects of SFBT may be effective in producing short term changes that will accumulate to further gains in symptom relief and overall functioning over time (Schmit et al., 2016).

In another meta-analysis, Kim (2008) found solution-focused therapy may be highly efficacious at reducing internalizing symptoms such as depression, anxiety, self-concept, and self-esteem, but not with externalizing behavior problems such as hyperactivity, conduct, or aggression or family and relationship problems. Kim (2008) suggested that future studies need to use standardized measures for brief therapy that possess satisfactory clinical sensitivity, especially for internalizing symptoms. Based on these recommendations, an empirical review by Gingerich and Eisengart (2000) found 15 outcome based research studies on SFBT for alleviating clinical symptoms using the Outcome Questionnaire-45.2 (OQ-45.2). These researchers suggested only one study of the 15 they reviewed directly examined the effectiveness of therapy and used empirically derived criteria for assessing the clinical significance of client outcomes using SFBT. The study they referenced is a study by Lambert (1998) which included 72 participants. Lambert reported 36% of the 22 SFBT patients recovered after 2 sessions and 46% recovered after 7 sessions. This study compared other time-unlimited eclectic treatment and

found 2% recovered after 2nd session and 18% recovered after 7 sessions. Based on the meta-analysis, Gingerich and Eisengart (2000) suggested using empirically derived criteria such as the OQ-45.2. Due to the dearth of literature that examines the clinical significance of SFBT, we evaluated SFBT using the OQ-45.2 with a culturally-diverse population.

In an extensive review of SFBT with Latino Spanish-speaking populations, González Suitt, Franklin, and Kim (2016) found two studies that utilized SFBT as primary interventions and four studies that combined SFBT with other therapeutic approaches such as cognitive behavioral, interactional, strategic family therapy, psychoeducation, and counseling. The two studies reported intervention with only SFBT were conducted in Latin America, with an adult population, and employed control groups that did not receive another type of intervention. The outcomes reported positive results on adult presenting psychosocial problems and couples aiming to improve marital satisfactions. Although their results suggest SFBT can apply to Latino populations, in the United States and in Latin America, they did not examine the extent to which SFBT alleviates clinical symptoms with Mexican American clients.

In a study examining solution focused brief therapy with clients of South Texas, (i.e., Mexican American and Mexican immigrants) Zamarripa (2009) provided case presentations to illustrate how student counselors can use SFBT to fit cultural perspectives. Their findings provide potential offerings to counselors-in-training in the utilization of SFBT with clients of Mexican-border town community. They implemented a client-centered approach, as delivered with SFBT, by allowing the clients to lead each session and following up with them. The purpose of their study was to not to generalize the use of SFBT, instead to focus on the uniqueness of the individual client and their story. The limitation to this study is that they did not measure client outcomes. Our purpose is to further investigate the effectiveness of solution focused brief

therapy with Mexican American population using a dual factor model to decrease clinical symptoms and increase feelings of hope.

Suldo and Shaffer (2008) argued that a dual -factor model of psychological functioning that incorporates positive and negative indicators of well-being into mental health assessment, positive subjective well-being and psychopathology, allows researchers and practitioners to measure and understand mental health. Subjective well-being refers to life satisfaction, hope, happiness, or positive affect (Diener, 2000) while psychopathology refers to internalizing and externalizing symptoms (Suldo & Shaffer, 2008). An examination of only psychopathology excludes important positive areas of mental health such as life satisfaction and hope.

Because solution-focused brief therapy fits within positive psychology's framework, it would be important to examine positive psychology constructs (Tereni, 2015). One of the most important constructs in positive psychology is hope (Cavazos Vela, 2014). C.R. Snyder (2002) has established a theoretical framework of hope theory and defines hope as a "positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed determination) and (b) pathways (planning of ways to meet goals)" (Snyder, Irving, & Anderson, 1991, p.287; Snyder, 2002). Then, he details the trilogy of concepts (goals, pathways, and agency) that builds this definition and the construction of hope.

His assumption is that people are likely to think in terms of goals and find motivations to achieve these goals; therefore, people's actions are usually goal directed. He explains that goals are the cognitive component of hope theory by providing a series of mental action sequences. To achieve a goal, one must think of ways to achieve them. Generating routes from point A to point B is termed *pathway thinking.* Pathway thinking becomes refined and precise as the goal pursuit sequence progresses toward goal achievement. However, differences in this process should

appear on the trait hope level of the person (e.g. The Trait Hope Scale). The motivational component of hope theory is the perceived capacity to use one's pathways to reach desired goals and is termed *agency thought*. This is the determination or mental energy to use pathway thinking in all stages of goal pursuit. Agency thinking is important especially when one encounters challenges or blockages so that alternative routes are produced. Because hopeful thinking is derived from pathways and agency thoughts, they all feed each other in pursuing goals. Because solution focused brief therapy is goal oriented, hopeful feelings are produced.

Reiter (2010) reported that hope may play a major factor in therapy by supporting positive change. Because clients usually seek help from counselors to improve their current circumstances, part of their hope is initially weak; therefore, clients initiate therapy with hope that change will occur. The emphasis on the future such as in solution-focused brief therapy help clients lead to an increased sense of hope (Reiter, 2010). Researchers found that enhancing positive emotion produced a significant increase in hope (Leontopoulou, 2015; Snyder, 2002). The increase of hope in therapy interventions was predicted as hope is linked with goal setting. Goal setting is one of the main routes to well-being (Leontopoulou, 2015) and is a main component of SFBT (de Shazer, 1991). Consequently, we examine changes of hope on the Trait Hope Scale to evaluate the therapeutic effects of solution focused brief therapy over time.

Fundamental Principles of Solution Focused Brief Therapy

Developed from the clinical practice of Steven de Shazer and Insoo Kim Berg, SFBT is a future-focused and goal-oriented approach that focuses on highlighting client knowledge and resources to search for solutions to resolve their own problems (Kim, 2008). A counselor's main therapeutic task is to help clients imagine how they would prefer things to be different and to determine what it will take to facilitate such change. Counselors take active roles by asking

questions to help the client identify when, where, and how the situation occurs to develop different perspectives. Additionally, a future focus on identifying how the client would like things to be when the problem is gone helps facilitate a more hopeful therapeutic context (Zamarripa, 2009). Counselors then amplify positive constructs (e.g., hope, gratitude, resilience) and their solutions by using specific strategies and techniques (Tambling, 2012) such as the miracle question, scaling questions, exceptions, experiments, and compliments (deShazer, 1991; Proudlock & Wellman, 2011).

Given that Mexican Americans are at risk for greater psychopathological issues and underutilize counseling services, it is suggested that these aspects of SFBT may be particularly helpful with culturally diverse populations whose experiences are often marginalized in main stream society (Zamarripa, 2009). Many Mexican American clients may present to counseling with clinic symptoms that stem from experiences where their strengths and competencies are often not recognized. A therapy approach that is not problem saturated, instead highlights client's strengths, sets small goals that lead to bigger ones, and build on what is already working, can reconstruct a positive future outcome for individuals who have endured many negative experiences based on ethnicity and cultural background (Zamarripa, 2009).

CHAPTER III

METHODOLOGY

We will implement a small series (N = 3) A-B single case research design (SCRD) with Mexican American clients admitted into treatment at an outpatient community counseling and training clinic to evaluate the treatment effect associated with SFBT for increasing hope and reducing clinical symptoms.

Participants

Clients

Participants in this study are 3 adults admitted into treatment at an outpatient community counseling and training clinic in the central Southern region of the United States who were between the ages of 20 to 34 years. All participants identified as Mexican American; two identified as female and one participant identified as male. During informed consent, we explained to participants that they would be assigned pseudonyms to protect their identity. All participants agreed to participate.

Client 1. Mary is a 31-year-old Mexican American female with a history of receiving student mental health services at a university counseling clinic for trauma-related difficulties. After a five-year period, Mary sought individual counseling services due to recent separation with the father of her three children, who was emotionally abusive. Mary stated that her Hispanic culture generated greater symptoms of anxiety while recognizing her new role as a

single mother. Mary's therapeutic goals and focus of treatment were to reduce clinical symptoms of anxiety as well as improve self-identity and self-esteem.

Client 2. Joel is a 20-year-old Mexican American male with a history of receiving mental health services during the previous semester for symptoms of depression. Joel's therapeutic goals and focus of treatment were to reduce clinical symptoms of anxiety and associated anger as well as improve self-esteem. Joel reported being a victim of domestic violence and child abuse. Additionally, Joel expressed distress with revealing his sexual identity due to patriarchal roles in the Hispanic culture that may result in rejection.

Client 3. Vilma is a 34-year-old Mexican American woman who was recently divorced and raising two daughters. Initially, she sought counseling services for her daughter but recognized she also needed counseling assistance. Vilma's therapeutic goals and focus of treatment were to reduce clinical symptoms of depression and anxiety due to termination of her marriage, as well as improve self-esteem and resiliency.

Therapists

The first therapist, who is lead practitioner in the current study, adapted solution focused brief interventions designed to facilitate positive feelings by helping clients set goals, focus on the future, and find solutions rather than problems. The primary practitioner is a counseling practicum student completing her graduate degree from a clinical mental health counseling program. The second therapist is also a student in the counseling graduate program. Prior to the study, they selected and designed interventions and activities according to specific guidelines from SFBT manuals and sources (Buchholz Holland, 2013; de Shazer et al., 2007; Trepper et al., 2010).

Supervisors

Two counseling supervisors monitored sessions to maintain fidelity of SFBT interventions. Bavelas et al. (2013) suggested that live supervision may provide a second set of clinical eyes to help therapists-in-training. Furthermore, videotaped supervision and transcriptions provided student counselors the ability to communicate with faculty supervisors between sessions. Individual supervisions between faculty supervisors and student practitioners were conducted on a weekly basis during the course of treatment. These measures were used to enhance immediate intervention by focusing on quality and competency of therapists-in-training.

Measurements

Outcome Questionnaire (OQ-45.2)

The OQ-45.2 (Lambert et al., 1996) is a 45-item self-report outcome questionnaire for adults 18 years of age and older. Each item is rated using a 5-point Likert scale (0=never, 1=rarely, 2=sometimes, 3=frequently, 4=always). Each item ranges from 0 to 4 with a range of a total possible score from 0 to 180. This assessment was designed to include items relevant to three domains central to mental health: symptom distress (SD), interpersonal relations (IR), and social role performance (SR) (Lambert et al., 1996). In this study, we will examine the Total Score to determine clinical significance (Beckstead et al., 2003). Previous psychometric evaluations have revealed internal consistency levels of .93 and test-retest reliability of .84 (Umphress et al., 1997). Test-retest reliability for subscale scores range from .78 to .82 with internal consistency estimates from .71 to .92 (Lambert et al., 1996).

Lambert et al. (1996) reported high internal consistency values (α = .93). In a study investigating the clinical significance of the OQ-45.2, Beckstead et al. (2003) estimated concurrent validity a .01 level (ranging from .55-.85) of the Total Score when compared to

Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1983), Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Zung Self-Rating Anxiety Scale (ZAS; Zung, 1971), Zung Self-Rating Depression Scale (ZSRDS; Zung, 1965), Taylor Manifest Anxiety Scale (TMA; Taylor, 1953), State-Trait Anxiety Inventory (STAI; Spielberger, 1983, Spielberger, Gorsuch, & Lushene, 1970), Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988), and the Social Adjustment Scale (SAS; Weissman & Bothwell, 1976).

Trait Hope Scale

The Trait Hope Scale (Snyder et al., 1991) is a self-report inventory to measure participants' attitudes toward goals and objectives. Participants responded to 8-statements evaluated on an eight point Likert-scale ranging from *definitely true* (8) to *definitely false* (1). Sample response items include, "I can think of many ways to get the things in life that are important to me" and "I can think of many ways to get out of a jam." Snyder and colleagues (1996) reported evidence of concurrent validity between hope and other measures regarding self-esteem, state hope, and state positive affect. Reliability coefficients range from .85 to .86 (Snyder et al., 2002; Vela, Lu, Lenz, & Hinojosa, 2015).

Context of Study

During the present study, each participant was involved in individual counseling at a community counseling clinic. The community that serves as the basis of this article is located in one of the top ten poorest places in the United States and where the vast majority (i.e., 86%) is from Mexican decent, including immigrants (Alemayehu & Semega, 2010). While understanding the reality of poverty, psychosocial stressors in the community, and the need to address mental health, our facility provides free counseling services to community members.

Because Latinos may underutilize mental health services or terminate prematurely, it is important to note that this may be due to economic or structural barrier and not the unwillingness to enter counseling (Zamarripa, 2009). Therefore, all sessions positively emphasized brief and direct interventions of SFBT to help clients recognize their strengths and past successes rather than deficits and problems that are often associated with this population. Furthermore, techniques demonstrated that clients have the power to create their own future, make small changes in behaviors that lead to larger changes, and to continue to do what already works (de Shazer et al., 2007). The following techniques were used throughout treatment: miracle question, scaling questions, solution-focused goals, experiments and homework assignments, looking for exceptions, compliments, and "so what is better" questions. Furthermore, amplifying exceptions, strengths, and successes, developing coping skills and strategies, and assessing attempted solutions were used to evoke the transformation from problem-oriented to solution-oriented conversations (Bavelas et al., 2013). Additionally, the positive nature and future focus of SFBT was implemented to induce feelings of hope for our clients (Reiter, 2010).

Participants in this study received 6-9 sessions of individual SFBT using the description of techniques and activities in *More than miracles: The state of the art of solution-focused brief therapy* (de Shazer et al., 2007), *Solution focused therapy treatment manual for working with individuals research committee of the solution focused brief therapy* (Trepper et al., 2010), and *The lifeline activity with a "solution-focused twist"* (Buchholz Holland, 2013).

Procedures

The current study complied with the following procedure. Based on voluntary participation, the data collection was taken at different intervals and by criterion sampling. Participants were over the age of 18 years old, seeking treatment due to depression and anxiety,

and identified as Mexican American on a phone interview. Participants were first informed, by the researcher, the goals of the study, any possible risks, an approximation of time needed to complete the study, and the process of administering the assessment at the beginning of every session. Once the individual agreed to partake in the study and the informed consent was signed, the participants were handed the Demographic Form (see Appendix A), Outcome Questionnaire -45.2 (see Appendix B), and the Hope Scale (see Appendix C). Once the participants completed all portions of the assessment, they were thanked and reminded that they would complete the OQ and Hope Scale every session until the completion of therapy. The total time needed to complete the study was fifteen minutes, per participant. The participant was asked to complete the two assessments (i.e., OQ and Hope Scale) again after intake was conducted. This provided the second baseline measure. The participant was thanked and dismissed. The following week, the assessments were taken before and after the Biopsychosocial. This provided the third and fourth baseline measure. The third meeting is when therapist began implementing SFBT and continued until treatment was terminated.

Data Analysis

We evaluated treatment effect using an A-B single case research design (SCRD) to determine the effectiveness of a SFBT treatment program (see Lundervold & Belwood, 2000; Sharpley, 2007) using scores on The Trait Hope Scale and OQ-45.2 total score as outcome measures (Lambert et al., 1996). Upon considering the percentage of data exceeding the median procedure (PEM) (Ma, 2006), we selected the percentage of non-overlapping data (PND) procedure because it is used to analyze quantitative data across several phases of treatment (Scruggs & Mastropieri, 1998; 2001) and is considered a robust method of calculating treatment

effectiveness (Lenz, 2013). This metric is conceptualized as the percentage of treatment phase data that exceeds a single noteworthy point within the baseline phase.

The PND procedure yields a proportion of data in the treatment phase that overlaps with a single baseline measure. Because we aimed for an increase in hope scores, the highest data point in the baseline phase was used. Finally, given that we aimed for a decrease in OQ-45.2 total scale scores, the lowest data point in the baseline was used (Lenz, 2013). To calculate the PND statistic, data points in the treatment phase on the therapeutic side of the baseline are counted: (a) the total of those that are above the baseline of the Hope Scale and (b) total of those below the baseline on the OQ. The data point of the baseline (i.e., highest on the Hope Scale baseline point and lowest on the OQ) is divided by the total number of points in the treatment phase (Ikonomopoulos et al., 2016). This will give an interpretation of effect size (i.e., PND value) on treatment outcomes (Sharpley, 2007).

PND calculations are expressed in a decimal format that ranges between zero and one with higher scores representing greater treatment effects (Lenz, 2013). PND values are typically interpreted using the estimation of treatment effect provided by Scruggs and Mastropieri (1998) wherein values of .90 and greater are indicative of a very effective treatment, those ranging from .70 to .89 represent moderate effectiveness, those between .50 to .69 are debatably effective, and scores less than .50 are regarded as not effective (Ikonomopoulos, Smith, & Schmidt, 2015; Ikonomopoulos, Vela, Smith, & Dell'Aquila, 2016). This procedure is completed for each participant's scores on the Hope and OQ-45.2 scales. A visual trend analysis reports these data points collected from each phase to graphically provide visual representations of change over time (Sharpley, 2007).

Additionally, we analyzed treatment outcomes of the OQ-45.2 by using the "most frequently used method for operationalizing clinical significant change" (Beckstead et al., 2003, p.86.), the Reliable Change Index (RCI). Described by Jacobson and Truax (1991), RCI is a two-step process that is obtained by subtracting a pre-treatment score from a post-treatment score and dividing by the standard error of the measurement (Beckstead, 2003). Because we took four baseline measures, we acquired the mean from these scores and used the outcome as a pre-test score. The second step is determining a normal functioning cutoff score. Based on normative and clinical data, Lambert et al. (2004) established a cutoff score and RCI for the OQ-45. Then, they developed categories based on change on the OQ scores and according to Lambert (2013), are as follows:

-*Recovered* (i.e. clinically significant change) - Clients whose score decreases by 14 or more points and passes below the cutoff score of 64.

-*Improved* (i.e. reliably changed) - Clients whose score decreases by 14 or more points but does not pass below the cutoff score of 64.

-*No Change*- Clients whose score changes by less than 14 points in either direction.

-*Deteriorated*- Clients whose score increases by 14 or more points

We calculated RCI from pre-treatment and post-treatment results for each client and labeled each client as recovered, improved, no change, and deteriorated. Illustration are on Table 3.

CHAPTER IV

RESULTS

Results from the Solution Focused Brief Therapy intervention are indicated below through scores on the Trait Hope Scale and the Outcome Questionnaire -45.2.

Hope

As illustrated on Table 1, the scores from each participant are documented during each session on the Trait Hope Scale starting with the four baseline measures (e.g. B1, B2, B3, B4). Then, the scores in the treatment phases are recorded by session. Provided by the results on this table, we conducted a PND analysis to assess treatment effectiveness. Figure 1 depicts estimates of treatment effect on the Trait Hope Scale. A detailed description on the trend analysis are provided by each participant.

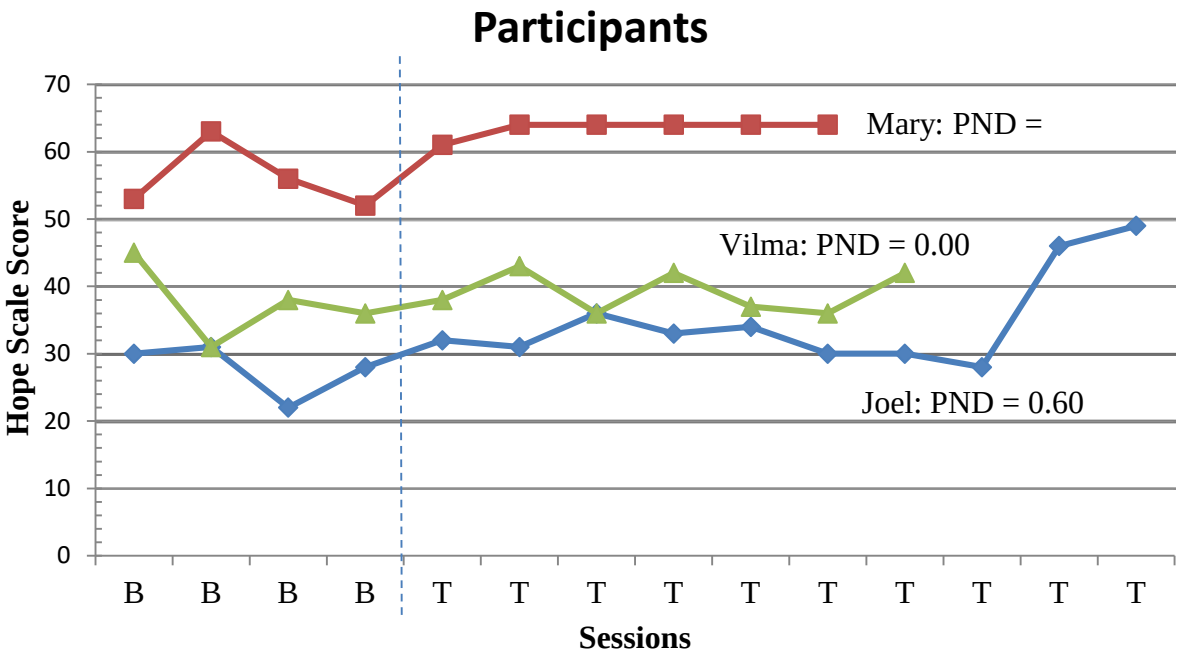
Table 1

Scores on the Trait Hope Scale

Participant	B1	B2	B3	B4	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10
Mary	53	63	56	52	61	64	64	64	64	64				
Joel	30	31	32	28	32	31	36	33	34	30	30	28	46	49
Vilma	45	31	38	36	38	43	36	42	37	36	42			

Figure 1.

Graphical Representation of Ratings for Hope by Participants



Participant 1

Mary's ratings on the Hope scale illustrate that the treatment effect SFBT was moderately effective (i.e., .70 to .89; Scruggs & Mastopieri, 1998) for improving her Hope scale score. Evaluation of the PND statistic for the Hope scale score measure (0.83) indicated that five out of six scores were on the therapeutic side above the highest baseline (i.e., Hope scale score of 63). Mary successfully improved hope during treatment as evidenced by improved scores on items such as "I've been pretty successful in life", "I usually find myself worrying about something", and "I worry about my health". Scores above the PND line were within a 1-point range. Trend analysis depicted a consistent level of improvement following the first treatment measure and eventually reached highest possible score of 64.

Participant 2

Joel's ratings on the Hope scale illustrate that the treatment effect of SFBT was debatably effective (between .50 to .69; Scruggs & Mastopieri, 1998) for improving his Hope scale score. Evaluation of the PND statistic for the Hope scale score measure (0.60) indicated that six out of ten scores were on the therapeutic side above the baseline (Hope scale score of 31). Joel successfully improved his hope during treatment as evidenced by improved scores on items such as "I can think of many ways to get out of a jam," "I can think of ways to get the things in life that are important to me," and "I meet the goals that I set for myself." Scores above the PND line were within an 18-point range. Trend analysis depicted a steady level of scores following the first treatment measure, with scores vacillating around the baseline score until the eighth treatment measure.

Participant 3

Vilma's ratings on the Hope scale illustrate that the treatment effect of SFBT was not effective (i.e., .50 or below; Scruggs & Mastopieri, 1998) for improving her Hope scale score. Evaluation of the PND statistic for the Hope scale score measure (0.00) indicated that seven out of seven scores were not on the therapeutic side above the baseline (Hope scale score of 45). Vilma did not improve hope during treatment as evidenced by stagnant scores on items such as "I can think of many ways to get out of a jam," "I am easily downed in an argument," and "my past experiences have prepared me well for my future." No scores were above the PND line. Trend analysis depicted scores vacillating around the baseline score following the first treatment measure.

Clinical Symptoms

Table 2 provides an illustration of the scores on the -OQ-45.2 recorded for each session. Figure 2 depicts estimates of treatment effect on the OQ-45.2 total scale using PND across all participants. Detailed description of participants' experiences is provided.

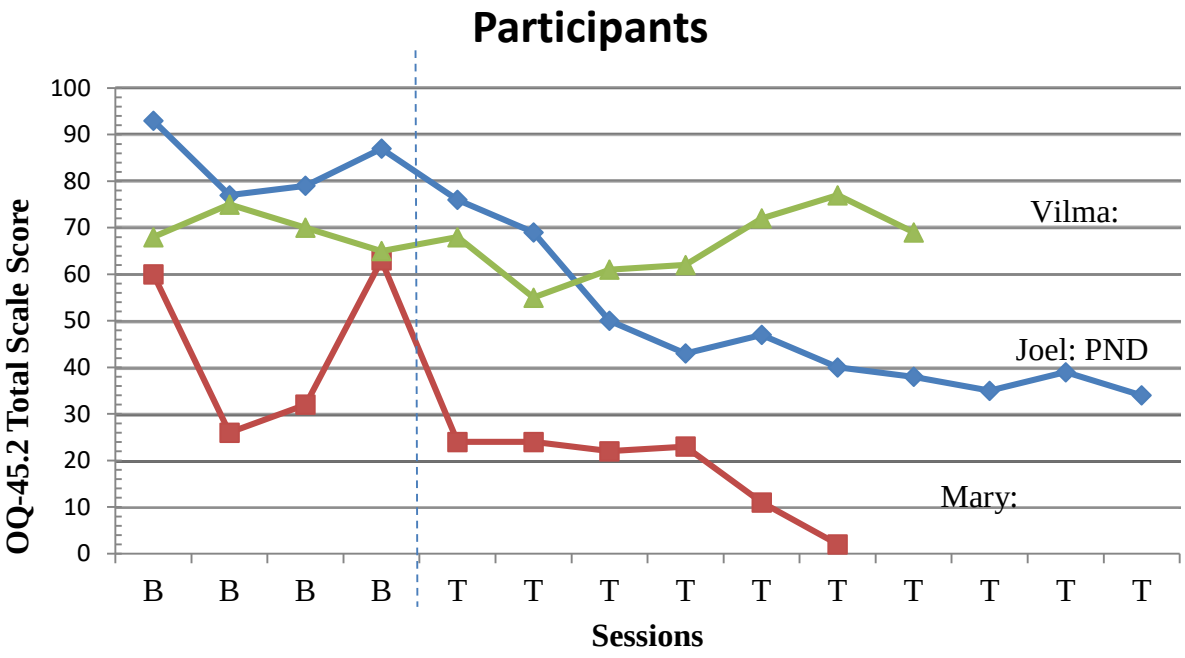
Table 2

Scores on the Outcome Questionnaire (OQ-45.2)

Participant	B1	B2	B3	B4	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10
Mary	60	26	32	63	24	24	22	23	11	2				
Joel	93	77	79	87	76	69	50	43	47	40	38	35	39	34
Vilma	68	75	70	65	68	55	61	62	72	77	69			

Figure 2.

Graphical Representation of Ratings for Mental Health Symptoms on OQ-45.2 by Participants



Participant 1

Mary's ratings on the OQ-45.2 illustrate that the treatment effect of SFBT was very effective (i.e., .90 or greater; Scruggs & Mastopieri, 1998) for decreasing her Total Scale Score measuring mental health symptoms. Evaluation of the PND statistic for the Total Scale Score measure (1.00) indicated that all six scores were on the therapeutic side below the lowest baseline (i.e. Total Scale Score of 26). Mary successfully reduced clinical symptoms during treatment as evidenced by improved scores on items such as "I am a happy person," "I feel loved and wanted," and "I find my work/school satisfying." This contention became most apparent after the first treatment session when Mary continuously scored lower on a majority of symptom dimensions such as symptom distress, interpersonal sensitivity, and social role. Scores below the

PND line were within a 24-point range. Trend analysis depicted a consistent level of improvement following the first treatment measure. Before treatment began, one of Mary's baseline measurements was above the cut-score guideline on the OQ-45.2 of a total scale score of 64, which indicates symptoms of clinical significance. However, an average of Mary's four baseline measures was 45 which illustrate a pretreatment score. After six SFBT sessions, Mary's scores decreased by 43 points.

Participant 2

Joel's ratings on the OQ-45.2 illustrate that the treatment effect of SFBT was very effective (i.e., .90 or greater; Scruggs & Mastopieri, 1998) for decreasing his Total Scale Score measuring clinical symptoms. Evaluation of the PND statistic for the Total Scale Score measure (1.00) indicated that all ten scores were on the therapeutic side below the baseline (Total Scale Score of 77). Joel successfully reduced clinical symptoms during treatment as evidenced by improved scores on items such as "I am a happy person," "I feel loved and wanted," and "I find my work/school satisfying." This contention became most apparent after the first treatment session when Joel continuously scored lower on a majority of symptom dimensions such as symptom distress, interpersonal sensitivity, and social role. Scores below the PND line were within a 41-point range. Trend analysis depicted a consistent level of improvement following the first treatment measure. Before treatment began, all four of Joel's baseline measurements were above the cut-score guideline on the OQ-45.2 of a total scale score of 64, which indicates symptoms of clinical significance.

Participant 3

Vilma's ratings on the OQ-45.2 illustrate that the treatment effect of a solution-focused therapy intervention was not effective (i.e., .50 or below; Scruggs & Mastopieri, 1998) for decreasing her Total Scale Score measuring clinical symptoms. Evaluation of the PND statistic for the Total Scale Score measure (0.43) indicated that three out of seven scores were on the therapeutic side below the baseline (Total Scale Score of 65). Scores below the PND line on the therapeutic side were only within a 10-point range. Trend analysis depicted a consistent level of worsening scores following the third treatment measure. Vilma unsuccessfully reduced clinical symptoms during treatment as evidenced by highest scores of fifth and sixth session

Reliable Change

According to Lambert (2013), because Mary's scores decreased by 14 or more and fell below the cutoff score, she *recovered* with therapy (Lambert, 2013). Joel averaged 84 on the baseline measures for pretreatment and ended with a score of 34 on the tenth session. This fifty-point decrease below the cutoff score of 64 illustrates Joel is *recovered* with therapy (Lambert, 2013). Before treatment began, all four of Vilma's baseline measurements were above the cut-score guideline on the OQ-45.2 of a total scale score of 63, which indicates symptoms of clinical significance. Vilma's pretreatment average is a score of 70 and after seven sessions, post treatment score is 69. This depicts that the client had no change with therapy (Lambert, 2013). Scores on pre-test, post -test, and reliable change are provided on Table 3.

Table 3

Reliable Change (RCI)

Participant	Pre-Test (Avg. of Baseline)	Post-Test (Last score)	RCI Category
Mary	45	2	Recovered
Joel	84	34	Recovered
Vilma	70	69	No change

CHAPTER V

DISCUSSION

The purpose of this study was to examine the impact of SFBT on clinical symptoms and hope among Mexican American clients. The results yield promising findings related to integrating SFBT with Mexican American populations. Two out of three participants reported a noteworthy amount of change in increases in hope as well as decreases in clinical symptoms. For Joel and Mary, SFBT appeared to be efficacious for increasing and maintaining scores on the Hope scale as well as decreasing scores on the OQ-45. It appears that there was a steady progression of improvement for these participants after their second treatment session. During this phase of treatment, practitioners used techniques such as exceptions to the problem and scaling questions to help participants recognize inner resources, analyze current levels of functioning, and visualize their preferred future. However, it is important to mention that inspection of participant scores within treatment targets revealed that SFBT was very effective for reducing clinical symptoms but only moderately effective for increasing hope.

Suldo and Shaffer (2008) argued that using a dual-factor model of mental health with indicators of wellness (e.g., hope) and illness (e.g., clinical symptoms) will provide a better understanding of overall mental health. Therefore, we agree that although a client's psychopathology might decrease, it does not mean that positive psychological functioning will increase with the same effect. Findings from SFBT treatment with Joel and Mary support a dual-

factor model that indicators of personal wellness and psychopathology are different parts of mental health and important to consider in treatment. Depending on the severity of clients' symptoms, SFBT may not address the needed depth for internalizing symptoms related to depression or anxiety (Schmit et al., 2016).

Vilma's scores seem to reflect the significant impact of her traumatic life experience during the course of the clinical trial. Vilma originally sought counseling treatment for herself and her daughter to cope with the emotional impact of a recent divorce from her husband of twelve years. The financial impact of the dissolution of her marriage forced Vilma to sell the family home and seek her parents' assistance with a temporary living alternative for herself and her two young daughters. Vilma's symptoms of depression and anxiety fluctuated from session to session based on her tumultuous relationship with her ex-husband. Disputes over child support, visitation time, and children' response to the divorce contributed to Vilma's fragile emotional state. We feel that Vilma's worsening scores reflected the emotional trauma which impacted her life during the length of the study. Other therapies that focus on accepting the past and dealing with the present might have provided more efficacious treatment with Vilma who appeared to struggle and cope with life changes.

Implications for Practice

Counselors-in training at community counseling centers can provide effective treatments associated with increase in hope as well as decrease in clinical symptoms. As a result, SFBT can be taught and infused into counselor education curriculum and can be delivered by Licensed Professional Counselors and/or school counselors. Community agencies working with this client population should also consider providing counselors with professional development and training related to SFBT. It is important to mention that the two practitioners of the current study were in

graduate programs and did not receive prior SFBT instruction. This might be due to greater emphasis on Humanistic and Cognitive Behavioral therapies. As a result, counselor educators must make a cogent effort to promote and discuss post-modern theories such as SFBT.

Second, SFBT is not specific to particular populations and is a potential option to work with other populations such as women engaged in intimate partner violence and adolescents with poor mental health. Other populations who experience similar issues might experience benefits from participating in SFBT individual or group sessions. We also encourage counselors to apply SFBT in small group settings, which have shown to be effective with various populations and presenting issues (Proudlock & Wellman, 2011).

Another important implication for counselors and counselor educators is to consider using SCRDs to monitor and assess treatment effectiveness. Lenz (2015) described how researchers and practitioners can use SCRDs to make inferences about the impact of treatment or experiences. SCRDs are appropriate for counselors or counselor educators for the following reasons: minimal sample size, self as control, flexibility and responsiveness, ease of data analysis, and type of data yielded from analyses. Counselor educators can teach counselors-in-training how to use SCRDs to monitor and assess treatment effectiveness with clients. Using SCRDs can provide counselors and counselors-in-training with an effective way to document and examine treatment effectiveness.

Implications for Research

First, researchers can evaluate the impact of SFBT on other outcome variables of psychopathology and positive psychological functioning, including subjective happiness, grit, meaning in life, and depression. More research needs to explore how SFBT might enhance positive psychological functioning and decrease clinical symptoms as well as the intersection

between recovery and psychopathology. Second, researchers should consider using qualitative methods to discover which SFBT techniques were most effective. In-depth interviews and focus groups with participants who experience SFBT would provide incredible insight and perspectives with the miracle question, scaling questions, and other SFBT techniques. Additionally, using between-group designs to compare SFBT interventions with evidence-based approaches such as Cognitive Behavior Therapy will be fruitful investigations. It is also possible to explore the impact of SFBT coupled with another approach with Mexican Americans.

Limitations

First, we did not include withdrawal measures following completion of the treatment phase (Ikonompoulous et al., 2016). Although researchers use AB and ABA single-case research designs, we did not use an ABA design that would have provided stronger internal validity to evaluate changes of SFBT (Lenz et al., 2012). The reason no withdrawal measures were conducted is that the clinic is open to the community during the semester hours; therefore, when the semester is over, the students are no longer are able to see clients. Another limitation is the potential to generalize to other Mexican Americans due to the small sample size. Finally, participants received 6-9 SFBT sessions over 12-weeks. Participants were inconsistent to treatment as two participants missed 2 weeks of counseling sessions while the final participant missed 3 weeks.

Conclusion

Using SFBT to help Mexican American clients in community counseling centers reduce clinical symptoms and improve hope should be considered. Based on the results of this single-case pilot investigation, SFBT shows promise as an effective method for improving hope and decreasing clinical symptoms. We recommend future research to continue to examine the impact of SFBT with larger sample sizes, different outcome variables, and different methodological approaches. In the current study, we provide guidelines for counselor educators and practitioners to consider when implementing SFBT treatment approaches for Mexican Americans. We also recommend that counselor educators and community agencies promote SFBT as it is a short term therapy that has been shown to impact hope and clinical symptoms.

REFERENCES

Alegria, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D., & Meng, X. L. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry, 165,* 359–369.

Alemayehu, B. & Semega, J. (2010). Income, earnings, and poverty data from the 2007 American community survey. *U.S. Census Bureau*. Retrieved from http://www.census.gov/prod/2008pubs/acs-09.pdf

Arredondo, P., Toporek, R., Brown, S., Jones, J., Locke, D., Sanchez, J., & Stadler, H. (1996). Operationalization of multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24,* 42-78. Retrieved from http://www.jmcdonline.org/

Ayon, Marsigliai & Bermudez-Parsai, (2010). Latino family mental health: Exploring the role of discrimination and familismo. *Journal of Community Psychology*, *38*(6), 742-756.

Bavelas, J., De Jong, P., Franklin, C., Froerer, A., Gingerich, W., Kim, J., Korman, H., Langer, S., Lee, M.Y., McCollum, E. E., Jordan, S. S., & Trepper, T. S. (2013). Solution focused therapy treatment manual for working with individuals. *Solution Focused Brief Therapy Association* 1-42.

Beckstead, D. J., Hatch, A. L., Lambert, M. J., Eggett, D. L., Goates, M. K., & Vermeersch, D. A. (2003). Clinical significance of the Outcome Questionnaire (OQ-45.2). *The Behavior Analyst Today*, *4*(1), 86-96.

Bermudez, J. M., & Mancini, J. A. (2013). Familias fuertes: Family resilience among Latinos. *Handbook of Family Resilience*. 215-227.

Buchholz Holland, C. E. (2013). The lifeline activity with a “Solution-Focused Twist”. *Journal of Family Psychotherapy, 24,* 306-311.

Calzada, E. J., Tamis-Lemonda, C. S., & Yoshikawa, H. (2013). Familismo in Mexican and Dominican families from low-income, urban communities. *Journal of Family Issues, 34,* 1696-1724.

Centers for Disease Control and Prevention. (2011). Youth risk behavior surveillance-United States, 2011. *MMWR, 61,* 1-162.

Chavira, D. A., Golinelli, D., Sherbourne, C., Stein, M., Sullivan, G., Bystritsky, A., & Craske, M. (2014). Treatment engagement and response to CBT among Latinos with anxiety disorders in primary care. *Journal of Consulting Clinical Psychology, 82,* 392-403.

Cuellar, I., Arnold, B., & Maldonado, R. (1995). Acculturation rating scale for Mexican Americans-II: A revision of the original ARSMA scale. *Hispanic Journal of Behavioral Sciences, 17,* 275-304. doi:10.1177/07399863950173001

Colby, S.L. & Ortman, J.M. (2014). Projections of the Size and Composition of the U.S. Population: 2014 to 2060. Current Population Reports, 25-1143. U.S. Census Bureau, Washington, DC.

deShazer, S. (1991). *Putting differences to work*. New York, NY: Norton.

de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I.K. (2007). *More than miracles: The state of the art of solution-focused brief therapy.* New York, NY: Hawthorne Press.

Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist, 55,* 34-43.

Dunn, M. G., & O'Brien, K. M. (2009). Psychological health and meaning in life: Stress, social support, and religious coping in Latina/Latino immigrants. *Hispanic Journal of Behavioral Sciences, 31,* 204-227. doi: 10.1177/0739986309334799

Ennis, S.R., Ríos-Vargas, M., & Albert, N.G. (2011). The Hispanic Population: 2010. 2010 Census Briefs, 1-16.

Gingerich, W. J., & Eisengart, S. (2000). Solution-Focused Brief Therapy: A review of the outcome research. *Family Process, 39*(4), 477-498.

Glover, S. H., Pumariega, A. J., Holzer, C. E., Wise, K. K., & Rodriguez, M. (1999). Anxiety symptomtomology in Mexican American adolescents. *Journal of Child and Family Studies, 8,* 47-57.

Gonzalez Suitt, K., Franklin, C., & Kim, J. (2016). Solution-Focused Brief Therapy with Latinos: A systematic review. *Journal of Ethnic and Cultural Diversity in Social Work, 25,* 50-67.

Hatchett, G. (2011). Training counseling students to work more effectively with short-term clients. *International Journal of Advanced Counseling, 33,* 206-215. doi:10.1007/s10447-011-9124-6

Hunt, J., Sullivan, G., Chavira, D. A., Stein, M. B., Craske, M. G., Golinelli, D., & Sherbourne, C.D. (2013). Race and beliefs about mental health treatment among anxious primary care patients. The Journal of Nervous and Mental Disease, 201(3), 188-195. doi:10.1097/NMD.0b013e3182845ad8

Ikonomopoulos, J., Smith, R. L., & Schmidt, C. (2015). Integrating narrative therapy within rehabilitative programming for incarcerated adolescents. *Journal of Counseling and Development, 93,* 460-471.

Ikonomopoulos, J., Vela, J. C., Smith, W. D., & Dell'Aquila, J. (2016). Examining the practicum experience to increase counseling students' self-efficacy. *The Professional Counselor*.

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice, 18,* 107-116.

Lambert, M.J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy, 50*(1), 42-51. doi: 10.1037/a0030682

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the outcome questionnaire. *Clinical Psychology & Psychotherapy, 3(4),* 249-258.

Lambert, M. J., Gregersen, A. T., & Burlingame, G. M. (2004). The Outcome Questionnaire. In M. E. Maruish, (Ed.), *The use of psychological testing for treatment planning and outcome assessment: Vol. 3. Instruments for Adults* (3rd ed., pp. 191-234). Mahwah, NJ:

Lenz, A. S. (2015). Using single-case research designs to demonstrate evidence for counseling practices. *Journal of Counseling and Development, 93,* 387-393. doi:10.1002/jcad.12036

Lenz, A. S., Speciale, M., & Aguilar, J. V. (2012). Relational-cultural therapy intervention with incarcerated adolescents: A single-case effectiveness design. *Counseling Outcome Research and Evaluation, 3,* 17-29. doi:10.1177/2150137811435233

Lundervold, D. A., & Belwood, M. F. (2000). The best kept secret in counseling: Single-case (N=1) experimental designs. *Journal of Counseling & Development*, 78, 92-102.

Ma, H. H. (2006). An alternative method for quantitative synthesis of single-subject researchers: Percentage of data points exceeding the median. *Behavior Modification*, 30, 598–617.

Magyar-Moeto, J. L., Owens, R. L., & Conoley, C.W. (2015). Positive psychological interventions in counseling: What every counseling psychologist should know. *The Counseling Psychologist, 43*(4) 508–557.

Morales, L. S., Lara, M., Kington, R. S., Valdez, R. O., & Escarce, J. J. (2002). Socioeconomic, cultural, and behavioral factors affecting Hispanic health outcomes. *Journal of Health Care for the Poor and Underserved, 13*(4), 477–503.

Munoz-Laboy, M., Ripkin, A., Garcia, J., & Severson, N. (2015). Family and work influences on stress, anxiety, and depression among bisexual Latino men in the New York City Metropolitan Area. *Journal of Immigrant Minority Health, 17,* 1615–1626.

Ojeda, L., Castillo, L. G., Rosales Meza, R., & Pina-Watson, B. (2014). Mexican Americans in higher education: Cultural adaptation and marginalization as predictors of college persistence intentions and life satisfaction. *Journal of Hispanic Higher Education, 13,* 3-14. doi:10.1177/1538192713498899

Ojeda, L., & Pina-Watson, B. (2013). Day laborers' life satisfaction: The role of familismo, spirituality, work, health, and discrimination. *Cultural Diversity and Ethnic Minority Psychology, 19,* 270-278. doi:10.1037/a0032961

Perreira, K. M., Gotman, N., Isasi, C. R., Arguelles, W., Castañeda, S. F., Daviglus, M. L., Giachello, A. L., Gonzalez, P., Penedo, F. J., Salgado, H., & Wassertheil-Smoller, S. (2015). Mental health and exposure to the United States: Key correlates from the Hispanic community health study of Latinos. *The Journal of Nervous and Mental Disease, 203*(9), 670–678.

Pina, A. A., & Silverman, W. K. (2004). Clinical phenomenology, somatic symptoms, and distress in Hispanic/Latino and European American youths with anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 33,* 227-236.

Priest, J. B., & Denton, W. (2012). Anxiety disorders and Latinos: The role of family cohesion and family discord. *Hispanic Journal of Behavioral Sciences. 34*(4), 557-575.

Proudlock, S., & Wellman, N. (2011). Solution focused groups: The results look promising. *Counseling Psychology Review, 26,* 45-54.

Schmit, E. L., Schmit, M. K., & Lenz, A. S. (2016). Meta-analysis of Solution-Focused Brief Therapy for treating symptoms of internalizing disorders. *Counseling Outcome Research and Evaluation*. doi:10.1177/2150137815623836

Scruggs, T. E., & Mastropieri, M. A. (1998). Summarizing single-subject research: Issues and applications. *Behavior Modification,* 22, 221–242.

Scruggs, T. E., & Mastropieri, M. A. (2001). How to summarize single-participant research: Ideas and applications. Exceptionality, 9, 227–244. doi:10.1207/S15327035EX0904_5

Sharpley, C. F. (2007). So why aren't counselors reporting n = 1 research designs? *Journal of Counseling & Development*. 85, 349-356.

Shin, S. K. (2009). Effects of solution focused programme on the reduction of aggressiveness and the improvement of social readjustment for Korean youth probationers. *Journal of Social Service Research, 36,* 274-284.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., et al. (1991). The will and the ways: Development and validation of an individual-differences measures of hope. *Journal of Personality and Social Psychology, 60,* 570-585.

Snyder, C. R., Shorey, H. S., Cheavens, J., Pulvers, K. M., Adams, V., & Wiklund, C. (2002). Hope and academic success in college. *Journal of Educational Psychology, 94,* 820-826.

Snyder, C. R., Sympson, S. C., Ybasco, F. C., Border, T. F., Babyak, M. A., & Higgins, R. L. (1996). Development and validation of the state hope scale. *Journal of Personal Social Psychology, 80,* 321-334.

Suldo, S. M., & Shaffer, E. J. (2008). Looking beyond psychopathology: The dual-factor model of mental health in youth. *School Psychology Review, 37,* 52-68.

Tambling, R. B. (2012). Solution-Oriented Therapy for survivors of sexual assault and their partners. *Contemporary Family Therapy, 34,* 391-401.

Terni, P. (2015). Solution-focus: Bringing positive psychology into the conversation. *International Journal of Solution-Focused Practices,* 3(1), 8-16.

Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2010). *Solution focused therapy treatment manual for working with individuals research committee of the solution focused brief therapy*. Retrieved from http://www.sfbta.org/researchDowloads.html

Vela, J. C., Castro, V., Cavazos, L., Cavazos, M., & Gonzalez, S. L. (2014). Understanding Latina/o students' meaning in life, spirituality, and subjective happiness. *Journal of Hispanic Higher Education.* doi:10.1177/1538192714544524

Vela, J., Lu, M. P., Lenz, A. S., & Hinojosa, K. (2015). Positive psychology and familial factors as predictors of Latina/o college students' psychological grit. *Hispanic Journal of Behavioral Sciences,* 37, 287-303. doi:10.1177/.0739986315588917

Wagstaff, A. E., & Polo, A. J. (2012). Ethnicity and adolescent depression: Prevalence, access to services, and promising intervention. *The Prevention Researcher, 19,* 8-10.

Zamarripa, M. (2009). Solution-focused therapy in the south Texas borderlands. *Journal of Systemic Therapies, 28*(4), 1-11.

BIOGRAPHICAL SKETCH

Krystle L. Ortega earned a Master of Education in Counseling and Guidance at the University of Texas Rio Grande Valley in December of 2016. She is a member of The American Counseling Association, The Texas Counseling Association, and Counseling and Guidance Student Association. Previously, Ms. Ortega graduated Cum Laude with a Bachelor of Arts degree in Psychology, May 2014, from The University of Texas at Brownsville. Krystle earned an Associate degree in Psychology, Magnum Cum Laude, from Laredo Community College in 2012.

Krystle Ortega was previously employed as a research assistant at UTRGV where she completed most of her research. Some of her work is under review for publication in the Journal of Humanistic Counseling, Hispanic Journal of Behavioral Sciences, and Journal of American College Health. Her current manuscript, *Evaluating Practicum Student's' Therapeutic Effectiveness Using Solution Focused Brief Therapy with Mexican American Clients: A Single Case Design,* will be submitted for review in The Journal of Professional Counseling. Her most recent effort will be implementing a parent facilitation intervention with divorcing couples.

Krystle Ortega is currently employed at Tropical Texas Behavioral Health assisting adults and families with mental health needs. Her career objectives are to continue with Tropical Texas toward obtaining a licensure as a professional counselor. If time permits, her goal is to pursue a doctoral degree and teach at a local university. Krystle receives correspondence through email at krys.ortega@gmail.com.