

**A Study of the Effectiveness of Solution-Focused
Brief Therapy on Anxiety and Depression in College
Students**

A

Thesis

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DECLARATION

I declare that the thesis entitled “A Study of the Effectiveness of Solution-Focused Brief Therapy on Anxiety and Depression in College Students” has been prepared by me under the guidance of Dr. Komal Rai, Assistant Professor, Dept. of Psychology, Lovely Professional University. No part of this thesis has formed the basis for the award of any degree or fellowship previously.

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CERTIFICATE

I certify that Seema Gupta has prepared her thesis entitled “A Study of the Effectiveness of Solution-Focused Brief Therapy on Anxiety and Depression in College Students” for the award of PhD degree of the Lovely Professional University, under my guidance. She has carried out the work at the Department of Psychology, Lovely Professional University.

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ABSTRACT

“Health is Wealth” an old proverb reflects the importance of health for everybody. Health is an asset that constitutes not only the absence of disease but also includes social and mental well-being. The process of calming of mind to stability has been called “chittavrittinirodha” in Yoga and has been emphasized since ancient times. The changing times have once again brought the focus on mental health as it has been found to be the cause of some non-communicable chronic diseases like cancer etc. Such disorders have led to morbidity and disability which in turn accounts for 13 per cent loss of total DALYs i.e. Disability Adjusted Life Years for years lived with disability (YLD). The depression has come up as the leading cause of this loss. With modernization and mechanization, there has been increased awareness, improvement in recognition, varied disease patterns, change in the lifestyle of the people and biological vulnerabilities. All this has led to an increase in anxiety, depression, substance abuse, etc. These disorders are prevalent in all age groups and irrespective of gender and other demographic factors. The etiology of mental disorders includes an interaction of physiological, societal, cultural and financial factors.

In India, the National Health Survey by NIMHANS report in 2016 reveals that the mental morbidity is 10.6 % for people above 18 years of age. The highest prevalence is of neurotic and stress-related problems, i.e. 6.93 % and mood disorders in second place with 5.6% according to NIMHANS report “1 in 20 people in India suffer from depression”. The age wise data of mental disorders reveals that the future of the nation i.e. the age group 18-29 also has a prevalence of 7.5 %. Even though the importance of mental health has been stressed since ancient times, yet it was neglected to some extent. The last few years have seen a lot of emphasis on the mental health. A goal has been set up to reduce the noncontagious diseases by treating and preventing them on one hand and promote mental health along-with the well-being to one third by 2030 (National Mental Health Survey of India, 2015-16: Summary, 2016). Moving in the same direction, India passed the Mental Health Care Act in 2017. The policy aims to promote mental health by focusing on the cure and prevention of mental disease. Despite a lot of efforts at providing cure and prevention of mental disorders, there is a large treatment gap in the range of 28% to 83%. The

data show that all states have less than 1 clinical psychologist per lakh population. Therefore, to prevent mental health problems, it is essential to deal with them at an earlier stage. The College students are the youth of the nation who have to take care of all the affairs in the future, efforts to help them deal with psychological problems are required. The youth has lot of stress but very fewer resources both in terms of time and money, so a time efficient- economical therapy is required.

Solution Focused Brief Therapy or popularly called SFBT is an evident-based brief therapy. Its effectiveness is being studied on different problems and with different age groups. The success rate of SFBT is, on one hand, making its roots stronger and spread its branches to different cultures on the other hand. Continuing the chain of research on SFBT, the present study is designed to see the effectiveness of Solution Focused Brief Therapy on Anxiety and Depression in College Students.

The advent of technology and modern lifestyle has, on one hand, made the living comfortable and on the other hand, increased stress leading to psychological problems. Psychological therapies ranging from Freud's psychoanalytic therapy, cognitive behavioral therapy, and rational emotive therapy by Ellis are available to treat such mental health problems. These psychotherapies, though effective in the long run, are quite time-consuming and costly. The client needs to attend sessions from months to years to gain benefits from traditional therapies. This requirement of time is like a hurdle in reaching the aim of the treatment as the individuals lack the patience to wait so long for getting desired results. Thus, they stop the treatment in between. The modern life has made the time even more scarce. So, looking at the practical problems of today's life, short and effective treatment therapies are desired. Working on this goal, solution focused brief therapy (SFBT) is developed. Brief therapy is a therapy in which the psychological intervention aims to get quick results either by setting a time limit in advance or not (Eckert, 1993). As the time taken by brief therapies is less, so they are gaining popularity in contemporary times. SFBT was developed almost three decades ago by Steve De Shazer et al (Berg & Shazer, 1993). The distinguishing feature of this therapeutic intervention is that it shifts the focus towards solution rather than solving problems. It works by aiming at present resources, future hopes and not paying much attention to existing problems or past

factors. It is completed in 3-5 sessions. It views clients as experts in their life and resources. So, SFBT is a client-centered and collaborative process.

It has come up as a popular therapy for helping people in different settings. It deals with mental health challenges like depression, anxiety, deliberate self-harm, obsessive compulsive disorders, schizophrenia, marital issues, caregiver burden, adolescent parenting, etc.

On the effectiveness of SFBT, results from a qualitative review of 43 studies shows that it is effective in almost 74 % of studies (Gingerich & Eisengart, 2000). It is quite effective in treating depression. In India, SFBT is still in its infancy. The Indian scenario, where the people have limited resources both in terms of time and finance and want immediate results, this type of therapy can become very useful and popular. With an anticipation of SFBT being effective in the Indian environment, we have introduced it as an intervention for anxiety and depression among college students.

Solution Focused Brief Therapy popularly called SFBT is a psychotherapeutic technique which focuses on solutions and not the causes of the problems. The therapy mainly progresses on the basis of an optimistic approach and is based on the premise that individuals are equipped with skills to solve their problems. The therapy looks at the individual as a rational being who can re-channelize his resources to solve the problems. The therapist helps the individual in need, to change his perspective from the problem to focus on the solution. It aims to develop practical and quick solutions to gain lasting relief to clients. SFBT has been applied to many different spheres of life like school, workplace and interpersonal problems.

The main steps of therapy include searching and finding solutions, helping the client in imagining the situation he wishes to attain, making him/her realize that how that change can be made real. The past or history of the client is not considered to be important. The whole attention is paid to the desired state, hurdles in the path of the desired state and helping the client recognize the available resources that can help to cross the hurdles to reach their goal. The focus is on crossing the hurdles and not removing the hurdles. SFBT is based on an presumption that the client has the capacity to imagine a change, will leave no stone unturned to reach the goal and the whole or part of change will start happening immediately (Weiner-Davis, de Shazer, & Gingerich, 1987). The therapy is very short and may conclude in even one session.

The Indian system is highly conducive to SFBT. It can also be said that SFBT is the need of the hour in the Indian system. The reason behind the relevance of SFBT in the Indian scenario is that on the one hand, the high pace of development is leading to an escalation of mental health problems, on the other hand the scarcity of time and finances require a quicker, economical and solution-focused approach. The SFBT is also relevant from another perspective. India which has a population of 1.25 billion out of which almost 20% of people are below poverty line and without any health insurance for mental illness. Apart from this, less than 1 clinical psychologist is available per 1 million populations (Rehabilitation Council of India, 2015). All these reasons point to the growing need for a time and resources effective treatment. The brief therapeutic treatment models are very vital for present Indian clinical scenario as they are quite economical and less time-consuming giving results in a short span of time.

This research is designed to study the effectiveness of Solution Focused Brief Therapy on Depression and Anxiety in College students. The objectives of the study are to study the impact of solution focused brief therapy on the level of anxiety and depression. The other objective of this study is to find out whether the demographic variable gender and socioeconomic status contribute to anxiety/depression in college students. To achieve the above-mentioned objectives, the hypotheses stated that the solution focused brief therapy will have a positive impact on the level of anxiety and depression in college student. It was also expected or hypothesised that the demographic variables will make a significant difference in the anxiety and depression in college students. The experimental study was conducted by randomly assigning subjects with mild to moderate depression/anxiety to the experimental and control group. The Beck's Depression Inventory was used for the testing of depression levels and Beck's Anxiety Inventory was used for the screening of anxiety levels among the experimental and control groups. The experimental and control groups were tested before the therapy and their score was recorded as a pre-therapy score. The experimental group was given SFBT and retested after the completion of the therapy. The control group was also retested. The post-therapy scores for both depression and anxiety were also recorded. After the pooling in of the data, the statistical tools were applied for interpretations. The paired sample t-test was used to

study the significance of the difference between the means of pre-therapy and post therapy scores of both anxiety and depression. As the value of paired t-test comes out to be significant, it implies that solution focused brief therapy had a positive effect on the college students' anxiety and depression levels. The independent samples t-test was used to test the similarity of the experimental and control groups before the therapy. The independent sample t-test value on the pre-therapy scores of anxiety and depression is not significant indicating the homogeneous nature of the two groups before the therapy. The independent samples t-test was also used to study significance of the difference between the experimental and control group after the therapeutic intervention to the experimental groups. The post-therapy comparison of the experimental and control groups with independent samples t-test reflects that the difference was significant. So, the intervention with solution focused brief therapy to the experimental group brought about significant differences than the control group which did not receive any intervention. The value of paired t-test and Repeated measures ANOVA of the experimental group before and after therapy on anxiety comes out to be significant. The result supports this hypothesis as the intervention solution focused brief therapy led to a decrease in the mean value of anxiety for the experimental group. The value of paired t-test of experimental group pre- and post-therapy on depression is significant at 0.01 level or 99% accurate. The Repeated measures ANOVA calculated to test the significance of the difference between the pre- and post-test experimental group also came out to be significant. The statistical analysis thus, supported the hypothesis that solution focused brief therapy will have a positive impact in reducing the level of depression in college students. So, this hypothesis is accepted.

At the beginning of the study, it was hypothesized that demographic variables will make a significant difference in anxiety and depression in college students. Independent sample t-test for anxiety and depression on gender difference and F-value of one-way ANOVA done to know the difference made by gender on anxiety and depression come out to be insignificant. This means that the results do not support this hypothesis. Hence, the hypothesis stating that demographic variables will make significant difference on anxiety and depression in college students is rejected.

The results reflect a significant change in the experimental group after the therapy. So, solution focused brief therapy has proved to be an effective therapy in the present study.

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List of Acronyms

AISHE	All India Survey on Higher Education
ANOVA	Analysis of Variance
APA	American Psychological Association
BDI	Beck Depression Inventory
BFTC	Brief Family Therapy Center
BIS	Behavioral Inhibition System
CPI(W)	Consumer Price Index Wages
CRF	Corticotrophin Releasing Factor
DALY	Disability Adjusted Life Years
DSM-5	Diagnostic and Statistical Manual-5
FFST	Formula First Session Task
GABA	Gamma Amino-butyric Acid
HPA	Hypo Thalami-Pituitary-Adrenocortical (HPA)
HRSD-R	Hamilton Psychiatric Rating Scale for Depression
KMSS	Kansas Marital Satisfaction Scale
LMIC	Low- and Middle-Income Countries
LTPP	Long Term Psychodynamic Therapy
NIMHANS	National Institute of Mental Health and Neurosciences
NMHS	National Mental Health Survey
OBC	Other Backward Classes

OQ	Outcome Questionnaire
RDAS	Revised Dyadic Adjustment Scale
REM	Random Eye Movement
SC	Scheduled Caste
SD	Standard Deviation
SES	Socio Economic Status
SFGT	Solution Focused Group Therapy
SPSS	Statistical Package for the Social Sciences
ST	Scheduled Tribe
STPP	Short Term Psychodynamic Therapy
TC	Taking Charge
US	United States
WHO	World Health Organization
YLDS	Years Lived with Disability

CHAPTER 1

INTRODUCTION

1.1 Solution Focused Brief Therapy

Solution Focused Brief Therapy popularly called SFBT is a psychotherapeutic technique that diverts the attention to solutions from the causes of the problem. The therapy mainly progresses on the basis of an optimistic approach and is based on the premise that individuals are equipped with skills to solve their problems. The therapy looks at the individual as a rational being who can re-channelize his resources to solve the problems. The therapist helps the individual in need, to change his perspective from the problem to focus on the solution. Recognizing the need for economical and time saving therapy, Steve de Shazer and Insoo Kim Berg from Milwaukee developed SFBT in the early 1980s at the Brief Family Therapy Centre in Milwaukee, Wisconsin (de Shazer, 1982, 1985, 1988; de Shazer, Berg, et al., 1986). It aims to develop practical and quick solutions to gain lasting relief to clients. SFBT has been applied to many different spheres of life like school, workplace and interpersonal problems.

1.1.1 How Solution Focused Brief Therapy Works?

SFBT works by helping people recognize their ability to solve the problems. It is based on the assumption that every individual has the skill to bring about a change in his/her life. The therapist has to just help in shifting the focus from the existing problems and anticipated goals to mobilize the resources/skills towards the solution. This goal is achieved by asking a question to guide the session. The questions pertain to resilience ability and tools which can help them to face life challenges. Such questions work like a miracle in helping the person recognize their ability and acknowledge the capability to solve the problems. Miracle questions make the people visualize life without a problem; help in identifying small things that can help make a change. The main challenge lies in how to make the client visualize a better life in such a way that it can serve as a motivator for desiring and working towards that ideal situation. The visualization of problem-free life acts as a motivator to solve problems. Researchers have found SFBT to be successful with the problems of youth like academics/school-related; family and couple counseling etc.

The solution-focused therapy developed in the time when there was a shift towards more pragmatic approaches along with being goal-directed and less time consuming (Visser, 2013). Milton Erickson, an American psychiatrist gave some key ideas which lead to the development of SFBT. Some of the ideas included are:

- The client has his/her own resources which can be used to find the solution to the problem.
- It is important to attend to the present and future instead of focusing on the past to find the solution.
- The earlier concept of crystal ball leads to the concept of a miracle question (Ratner, George, & Iverson, 2012).

The main steps of therapy include searching and finding solutions, helping the client in imagining the situation he wishes to attain, making him/her realize that how that change can be made real. The past or history of the client is not considered to be important. The whole attention is paid to the desired state, hurdles to that desired state and using all available resources to cross the hurdles to reach their goal. The focus is on crossing the hurdles and not removing the hurdles. SFBT works with a presumption that the client has the capacity to imagine a change, will leave no stone unturned to reach the goal and the whole or part of the change will start happening immediately (Weiner-Davis, de Shazer, & Gingerich, 1987). The therapy is very short and may conclude in almost six sessions.

1.1.2 Steps of Solution Focused Brief Therapy.

De Shazer observed that the clients have the ability to solve their problems without knowing or understanding the cause or nature of the problem. With this premise, the structure of solution- focused therapy is distinct from problem-solving. The basic steps can be enumerated as follows:

- 1. Problem description:** The first step of the therapy helps in knowing the details of the problem. In SFBT this is usually done by asking the client: “How can I help you?” or “How can we be useful to you?” Commonly the client responds by narrating the problem. Unlike other therapies, very few details are asked and very less time is spent on knowing the details of the problem or cause of the problem.

The focus of the therapist is to listen to the problem talk of the client and turn it into a solution talk at the earliest.

- 2. Developing well-formed goals:** The next step in solution-focused therapy is to help the client to visualize life when the problems are solved. This is done at a point in this therapy where other approach therapists are just assessing the causes or problems.

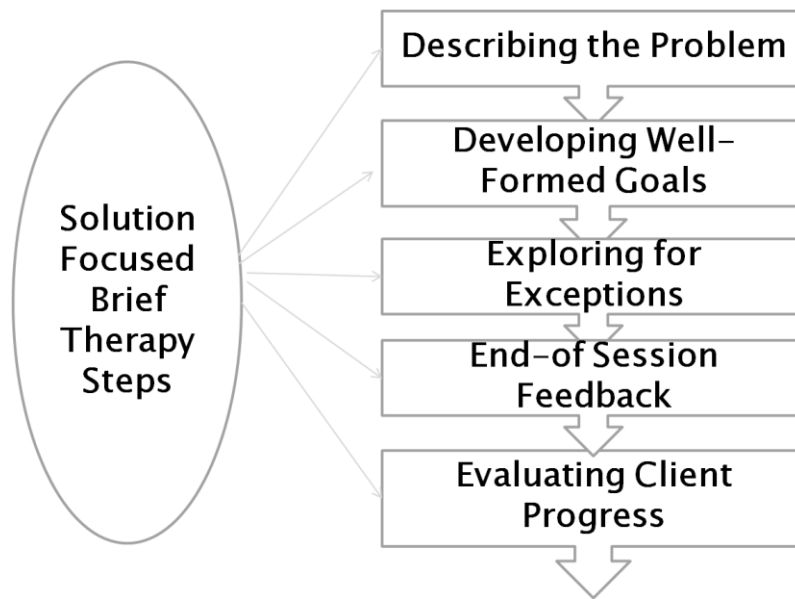


Figure 1.1 Showing the Major steps in Solution Focused Brief Therapy

- 3. Looking for Exceptions:** The client is encouraged to talk about the situation, time or the day when the problem was absent or lesser. The therapist also tries to know what was done and by whom in making the problem less severe or absent. In other words, the therapist tries to identify the tool for the exception. This step is similar to intervention planning in other problem-solving approaches.
- 4. Feedback in the last:** After therapy, towards the end of each session, the client is given some feedback. This feedback is an important part of solution -focused brief therapy. The concluding feedback includes compliments as well as suggestions. The compliments include the strengths of the client which are useful for dealing with the problems. The suggestions include information which can help the client solve problems. These compliments and suggestions are the summaries of information provided by the client during the therapy. The concluding remarks guide the client about what can be done more frequently or differently to reach

their goals. This feedback is given at a point where the other approach therapists do interventions.

- 5. Evaluating the progress:** In a need to evaluate the progress of the client, the therapist evaluates the progress through Scaling. The scaling is a technique used by the therapist to know the improvement in the client. The scaling means that the therapist asks the client to assign a number from 0 to 10 to the felt progress. The client scales his position between 0 and 10 and then sets up the goal where he/ she want to reach. Then the therapist and client work out the ways with which the desired goal can be attained, and the client is sufficiently confident to terminate the therapy.

So, the solution building approach does not have a prolonged engagement or termination stage. It works continuously by engaging and monitoring the client in each session.

1.1.3 Differences between solution building and other approaches.

- Solution building considers the client as an expert of his/ her life whereas other approaches view the therapist as an expert.
- Helping professionals help clients by applying scientific knowledge about problems and solutions. So, in this way therapist is seen as the expert helping the clients. On the other hand, the solution building therapist helps the client know or identify his/ her strengths.
- In traditional approaches, the perception of the therapist and client is different and sometimes gets in the way of therapy as client resistance which has to be worked out in order to help the client. In solution building, the therapist considers the client as an expert in his/ her own life. The client's frame of reference is given importance in the following ways:
 - i. The therapist tries to know from the client what change he/she wants to see in their life; the client describes the problems, and these are accepted by the therapist in their words only.
 - ii. The therapist finds out that when the problems are solved, what difference that will make in the client's life. Whatever the client says is

listened to and respected and the client's words and directions in which they want to go are also given attention.

- iii. The therapist looks for the client's perception of the situation, time or days of exception to their problems. These perceptions are considered as clients' inner strengths and sources of information about the resources that are there in their life.

So, in this, the clients' frame of reference is given the importance which helps in nullifying the emergence of any resistance (De Jong & Berg, 2001; de Shazer, 1984). This approach also helps in working with clients from diverse backgrounds or with diverse problems. This procedure also shows that the therapist does not consider himself/herself as an expert with scientific knowledge assessing the client. Here the solution-focused therapist tries to be an expert at understanding the clients' frame of reference and perceptions to live a better and satisfying life.

1.1.4 Some important concepts of Solution Focused Brief Therapy.

Solution-focused brief therapy has some unique features. Concepts or techniques that make the solution-based approach unique are:

- 1) **Not Knowing:** The term coined by Anderson and Goolishian (1992) implies that the therapist doesn't know the importance of the client's experience and actions beforehand i.e. on the basis of his expertise or knowledge, but he instead relies on the client's frame of reference. The 'not knowing' position helps the therapist to be genuinely curious about the client's problem and avoid implementing any preconceived ideas (Anderson & Goolishian, 1992)
- 2) **Interviewing skills:** Insoo Kim Berg stressed on the need to develop a solution building ear, in the process of listening to the client, by the solution building therapist. The therapist should be able to listen to the client's narration without adding or subtracting according to his/her own frame of reference. For example, if the young client says that his parents are 'old fools' then the therapist may evaluate by thinking that it is not right to call parents a 'fool'. Such evaluations from the therapists' frame of reference may interfere with the listening process, which is the essence of the therapy. The reasons of interference are:

- a) It is difficult to do the processes of listening and evaluation at the same time. In the process of listening and thinking about the first statement, it is quite difficult to listen or absorb the next statement.
- b) Another problem at early evaluation is reaching an early conclusion. Such conclusions are based on a personal frame of reference of the therapist and ignore the client's perspective to some extent.

These problems are taken care of in a good therapy by encouraging listening and developing skills for the same as a part of assessment skills in the therapist. In Solution focused brief therapy, Jong introduced role playing as the first stage, of course, to develop listening and responding efficiency in the therapist. The development of listening and responding skills helps the practitioner concentrate on the important aspects as per the clients' 'frame of reference', prevents evaluation of the client and keeps a check on the therapist preventing him from jumping to the problem- solving conclusions from self- perspective.

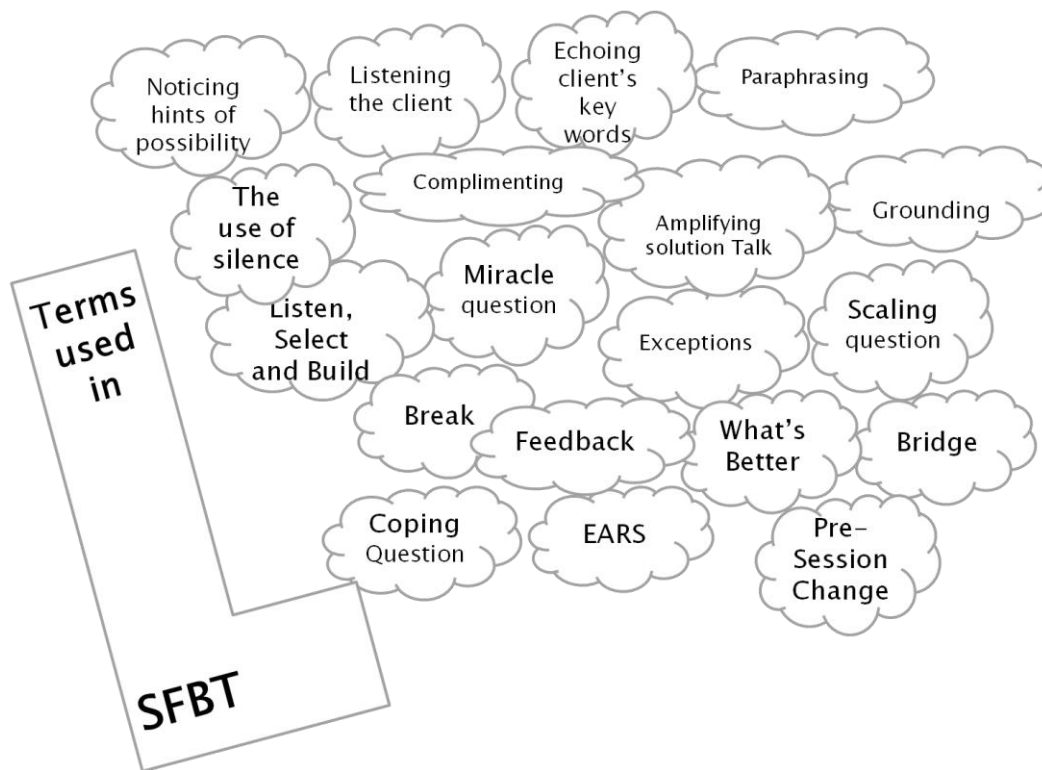


Figure 1.2 Showing the terms used in the Solution focused brief therapy.

3) **Attending to the Hints of Possibility:** According to Witkin “Noticing involves extracting something from a context” (Witkin, Noticing [Editorial], 2000, pp. 101-104). Normally, in any session, the client narrates his/her aspect of life, but the therapist is not able to notice each and everything. The therapist tends to notice what he feels is important from his perspective or what is of his interest or important from his point of view. So, in other words, whatever is noticed depends on the interest, belief, and acceptance by the noticing person. In solution-focused therapy, a *purposefully selective* interview is promoted. This means that the therapist is trained to be a good listener and notice statements that may act as the start of conversation towards the direction of solution. Most of the time the client is narrating whatever is troublesome to him and leading causes of the problem in his/her life. It is quite important for the therapist to listen attentively to gain the confidence of the client, to know the whole situation. But this does not imply that the repetition of the same problem should be allowed as it may discourage the focus on the solution both by the client and the therapist. So, the tendency to get into the vicious circle of repetitive problem talk has to be avoided and this is one of the biggest challenges. The best way to avoid this is by being alert; listen to any mention of the exception or past success or anything different that the client wants to happen. These aspects are mostly part of the client’s conversation but are mostly overlooked by the therapist at the unconscious level. So, the solution-focused therapist is trained to listen and notice a hint of the possibility of a solution. This can be seen in this example: a college student, whose girlfriend has been married to some other guy, finds it difficult to forget her. He narrates how much time he has spent with her, how they lived together and how she took care of his each and every requirement. He tells about his feelings. He also tells that the girl is not happy with her new family. He says that he wants to see her happy. He can do anything for her happiness. Now as a solution-focused practitioner, the therapist will say that you can do anything for her happiness. “What do you think you can do to make her happy?” “How can you help her?” “What do you think are the options available for you?” In this way, the therapist will move in the direction of a solution rather than focusing on the problems or the reasons for the different problems in the past.

4) Compose questions: In an interview, the most important challenge is the framing of the question. The therapist listens to the client's narration and then asks question. He has to frame question after listening to every answer. Witkin has suggested that "Listen to the questions people ask and you get a fairly good idea of what they believe, what they value, and what they hope to accomplish" (Witkin, 1999, pp. 197-200). As a solution-focused therapist one is supposed to frame solution focused or hope building questions which is quite different from what is normally practiced. For example, instead of asking "Why did your girlfriend married someone else?" "Why is she not happy?" the solution-focussed therapist asks, "What can you do to make her happy?" "Suppose a miracle happens, what different will you notice?"etc. The process of asking questions and listening to answers is a process of creating awareness and directing focus from problems to new possibilities. The person after the solution building conversation will mostly say that he had never looked from this perspective (LaFrance, 1992; McGee, 1999; McGee, Del Vento, & Bavelas, 2005; Witkin, 1999). The solution focused therapist is advised to follow the principle of making the next question from the clients' previous or early answers. The importance of this principle lies in the fact that

- i) This helps in putting into action the idea that question and answer help in increasing the knowledge and give rise to new possibilities.
- ii) This helps in keeping the process of therapy within the perspective of the client as the follow-up questions are asked to get more information about what was told by the client.

5) Getting Details: Normally the clients' statement that all is going well is accepted by the interviewers. In solution building approach, the interviewer makes further inquiry into such statements. For example: if the client says that all going well between me and my mother, the interviewer will respond: "Oh, everything is going well between you and your mother, that's great. Congratulations! What tells you that all is well between you and your mother?" Getting further details is like asking about what, when, who, where and how of such statements. Such questions help in getting clarifications and amplify clients' strengths, successes and goals. It

is always better to avoid 'Why' questions as they lead to analyses and may make the interviewer judgemental which is not useful in solution building.

- 6) Echoing Clients' Key Words:** Another important skill in solution focused therapy is echoing clients' keywords. Echoing is repeating the utterances or phrases used by the client to describe his/her perspective or problem. While echoing the clients' words the therapist just repeats the terms used by the client to narrate his/her state or condition. The sentences of the client may not be that meaningful. By echoing the words from the answer, the therapist the response is clarified, or the details of the response are enquired. The therapist does not need to always reframe the answer of the client into question. He may only repeat a few words with an inquisitive tone. For example, the client may say he really had a bad experience. The therapist may simply repeat or echo the words "bad experience". The client will take it as an opportunity to detail out the keywords bad experience. The clients' keyword's can be identified by noticing the words' being repeated by the client i.e. the client often repeats the keywords. So, if the therapist notices the client repeating a word which the therapist has not explored, then he should be curious to know the details. Hence, language is an important source of information from the clients' perspective. From the solution building perspective, it is important to listen attentively and explore the clients' usage of words. Paying attention and exploring the utterances is also a way of manifesting deference to the client. Reframing the client's keywords into professional jargon is quite disrespectful and hence discouraged.
- 7) Incorporating Clients' Words:** One of the cardinal features of solution building approach is echoing the clients' keywords and incorporating the clients' language into therapists' questions. This enhances an understanding of clients' frame of reference and makes them feel respected and understood. This also helps in bridging a connection between the therapist and the client.
- 8) Open and Closed Questions:** The research literature emphasizes the use of open to closed questions during interviews. According to Benjamin (1987) closed questions lead to narrowing of the clients' perspective while the open questions widen the clients'' attention field. Another feature of closed question is that they help in eliciting hard facts while the open questions help in knowing the attitudes,

thought processes, feelings, perceptions, etc. A closed question presents a chance of revealing the interviewers' 'frame of reference' whereas the open questions help in being attentive to the clients' 'frame of reference'. The samples of open and closed questions are:

- a) "Can you tell something about how you feel about studies" vs. "Do you find hard to study?"
- b) "Can you tell me about the relationship with your parents" vs. "did you talk to your parents regarding staying out?"
- c) "If things are better, how will your relationship be different" vs. "Do you want your relationship to be better?"

The open questions are used to get specific information from the client. The use of open questions along with echoing and incorporating clients' words is one of the effective methods of knowing whatever is important from the clients' perspective. Open questions or statements are also an extension of the commitment to not knowing. As a therapist, every effort is made to cast the client as experts of their own lives. Asking the open questions with genuine curiosity in a way transfer the full control and responsibility to the client. So, open questions promote the expression of respect towards the client and promote their self-determination. But this does not mean that close questions are not used at all in solution building. Closed questions also help elicit specific information. For example one can ask, do you think you can clear your exam in one attempt? Though this is a closed question, yet this is an important question and its answer can be a good base to gather more information with the help of open questions.

- 9) **Summarising:** Summarising is restating the clients' thoughts, feelings and actions periodically along with echoing and open questions. Often summarising helps in reflecting what the interviewer has understood from the clients' narration. If there is any misunderstanding, the client can usually correct it. So in this way, the summarising helps the client control the description of his/her life. They also help the interviewer in framing further questions. Carl Rogers also promoted the use of summarising in his non-directive therapy. Summarising helps the listener to attentively listen to the speaker's ideas, thoughts, responses and behavior when

normally it is difficult to do so. Rogers has demonstrated the effect of summarising in the following exercise:

“The next time you get into an argument with your wife, or your friend, or with a small group of friends, just stop the discussion for a moment and for an experiment institute this rule: Each person can speak up for himself only after he has first restated the ideas and feelings of the previous speaker accurately, and to that speaker’s satisfaction” (Rogers, 1961, p. 332)

According to Rogers, successful summarising involves attentive listening that helps in removing heightened emotion from the discussion by rationalizing the differences among the participants and making them more understandable.

10) Paraphrasing: “Paraphrasing, sometimes called a reflection of content, feeds back to the client the essence of what has just been said. The listener shortens and clarifies the client’s comments” (Ivey, Ivey, & Zalaquett, 2014, p. 140). The difference between paraphrase and summarising is that the former are briefer than the later and the client’s chain of thought process is not interrupted by them. The role of paraphrasing is that they ensure that the interviewer is carefully listening to the client. Like summarising, paraphrasing also includes the client’s keywords. Another role of paraphrasing is that it helps in moving the conversation in the direction desired by the interviewer. In other words, paraphrases are not totally passive, neutral or objective. An effective paraphrasing includes a pause in the discussion offer caveat. Though literature emphasises the reflective nature of summarising and paraphrasing (Ivey, Ivey, & Zalaquett, 2014; Rogers, 1961) the research of three types of practices i.e. cognitive- behavioural , motivational interview and solution-focused shows that they transform client’s words sometimes less and sometimes more (Korman, Bavelas, & De Jong, 2013).

11) The use of silence: Epstein (1985) from his research concluded that the interview learners tend to find it very difficult to maintain silent pauses in interviews. The new practitioners tend to freeze during silence (Epstein, 1985). The interviewer during the silence phase starts feeling as if he is unable to help the other person and as Epstein says engages in destructive self-talk: “I can’t do it. I’m making a fool of myself. Worse yet, the client knows’ that I don’t know what I’m doing”

(Epstein, 1985; De Jong & Berg, 1998, p. 33). The silence has different meanings for the practitioner and the client. The client may be silent because he/she is taking time to sort out his/her thoughts, is trying to come out of the emotional feelings about the recently described situation, or taking a short breath and the therapist should respect his/her silence. (Benjamin, 1987). Solution-focused therapy encourages the interviewer to tolerate the silence of the client. The solution-focused approach requires the practitioner to ask questions about the expectations or changes desired by the clients. Such questions require the client to reorient his focus and so he may take time in responding resulting in silence. So, if the interviewer is able to tolerate the silence of 5-20 seconds, the client's responses will surprise him/her. As solution building requires the client to think in a new direction, i.e. from problem expression to solution-focused, they take time to respond and may sometimes break the silence by simply saying "I don't know?" or "I never thought that way?". So, the practitioner has to learn to be patient enough to bear the silence and wait for the client's response. In fact, the practitioner has to encourage and motivate the client to elicit a response by saying "yes, it is a tough question or yes, you can do it". The interviewer can also ask additional questions to help the client come up with an answer. Sometimes, the client also gets uncomfortable with silence. The therapist has to help the client in eliciting a response to break the silence by remaining silent. In the process, the client learns that he/she has to himself/herself come out with the solution and the therapist will not answer the question on the client's behalf. The exceptions to this situation are the situations where the client has come under any compulsion, and so may not respond to the therapist's question or the client has not understood the question. The therapist has to be cautious and take help of other techniques in such situations.

12) Practitioners' Nonverbal Behaviour: Practitioners nonverbal behaviour is very important for the client. The client pays attention to the practitioner's behavior and makes sure that the practitioner is listening to him/her carefully or not. While responding or during the silent phase, the client pays attention to the therapist's expressions or nonverbal behavior. So, interviewers, nonverbal behavior is very important in establishing rapport or the cooperative working environment during

the therapy (Egan, 2010; Ivey, Ivey, & Zalaquett, 2014; Okun & Kantrowitz, 2008). The face and body posture is most communicative. Some other important aspects of therapeutic interviews are as follows:

- a) Eye movement and eye contact
- b) Facial expression
- c) Voice tone, intensity or volume, etc.
- d) Other physiological responses example breathing rate, blushing etc.
- e) The therapeutic room, the distance between the therapist and the client, etc.

So, nonverbal behavior is an important aspect of therapy. In solution building, it is believed that if the interviewer maintains the position of not knowing, notices hints of possibility, using summarizing and paraphrasing, etc. his/her nonverbal behavior will be maintained automatically and make the therapy effective. Still, if the interviewer feels, he can use a video recording of the therapeutic session to take feedback on his/her own behaviour and work on required gestures or cues.

13) Noticing Client's Nonverbal Behaviour: The research on counselling and interviewing skills has found that the client's nonverbal behaviour is also an important source of information (Egan, 2010; Ivey, Ivey, & Zalaquett, 2014; Okun & Kantrowitz, 2008). It has been found that clients use rolling of eyes, putting down head; heave a sigh, cross legs, cross arms, change the tone of voice or silence as means of nonverbal communication (Okun, Fried, & Okun, 1999). Though the client's nonverbal behavior is quite important, yet a solution building approach does not give it that important to its interpretation. The solution building approach encourages the therapist to move with not knowing questions to know the client's frame of reference. The solution building requires the interviewer to pay attention to the client's nonverbal behaviour to know whether the questions being asked are appropriate and relevant to his/her frame of reference. For example, if the client is silent, starts looking away or starts losing interest then this may be an indication of something wrong in the questions being asked and the interviewer should ask something different. On the other hand, if the client starts pressing his/her lips, narrows his/her eyes then this may be taken as an indication of the need to ask additional questions in the same context.

14) Self-Disclosing: Self-disclosing is the therapist sharing of his/her own experiences with the clients (Ivey, Ivey, & Zalaquett, 2014). There are variations in the use of this self-disclosing among different practitioners. Some feel that it is a good way of motivating the client whereas others believe that this may interfere with self-determination and self-confidence of the client. The solution building approach again does not recommend self-disclosure. The solution building requires the interviewer to maintain not knowing stance and try to know the client's perspective or frame of reference. However, self-disclosure can be used in solution building to bring about any contradictions in the statements made by the client or to get more clarification regarding the client's viewpoint being presented. It is thought that sharing own experiences can limit the client's ability to solution building and hence considered unnecessary in solution-focused brief therapy.

15) Complimenting: Every client has some strength like a sense of humor, ability to do hard work, caring for others, understand other's points of view, good listening ability, etc. that may help him/her in resolving the problems and live a more satisfying life. Clients' past successes are situations where the client was able to face the problem and resolved the difficulty with his/her own ability. Reality-based complimenting is promoted in solution building approach. The interviewer compliments the client when he/she communicates any success in the past. In solution building, complimenting was first introduced to be given towards the end of the interaction to draw attention to the strength or earlier or previous success of the client. But later on, the interviewer started complimenting throughout the session as complimenting helped in making the client more hopeful and confident. Compliments are of different types:

- a) Direct compliment: It is a constructive or useful response given by the interviewer to the client's response. For example, if the client said that "I studied whole night" then the interviewer can complement saying "it appears that you are really a very hard-working student".
- b) Indirect compliment: Indirect compliment is a compliment in the form of a question. This type also helps in eliciting more information from the client. For example, the interviewer may say "How did you manage to study so hard?" An indirect compliment is considered a better option than a direct

compliment as the question format helps the client know more and state his/her own strengths and resources.

- c) Self-compliment: Sometimes the client may give a statement like “I decided to complete the chapter at any cost”. The practitioner has to be attentive for such statements as they indicate success on the client’s part and reinforcement of such statements can be really helpful. Normally the interviewer responds to self-compliments by asking “Was that difficult?”

So, compliments are quite an important part of solution building. Some clients accept compliments whereas others may downplay them. Sometimes the practitioner may also start feeling anxious. So, the practitioner should remember to use the compliment as a tool to bring about positive change or bring into notice the client’s strengths.

16) Affirming Clients’ Perceptions: One important principle of relationship building is a purposeful expression of feelings (Biestek, 1957). The client’s request for help is related to the feeling of the need to purposefully express to be able to be understood and to trust the interviewer. Some quotations regarding the importance of understanding the client’s feelings are:

“The purpose of reflection of feeling is to make emotional life more explicit and clearer to the client- discovering the ‘heart of the matter.’ Underlying clients’ words, thoughts, and behaviors are feelings and emotions that motivate and drive action” (Ivey, Ivey, & Zalaquett, 2014, p. 160).

“Responding to feelings is the most critical single skill in helping” (Carkhuff, 1987, p. 99).

So, understanding feelings is an inseparable aspect of the ability to solve a problem by the client. The practitioner with this belief often tries to make out the emotional responses of the client from their conversation. They also try to see whether the client takes the responsibility of their emotions or shift responsibility to provocations by others. Contrary to this viewpoint, is the notion that perception of the client which includes their attitude, feelings and thinking are found to be important. So, Insoo stressed the need to understand the perceptions of the client and give them affirmation. Instead of separating feelings from attitudes or past behaviour, it is important to know the perceptions holistically. The grasping of the

perceptions leads to their affirmation as meaningful. This helps in understanding the client, helping him/her attain their goal, develops trust and maintain a good productive relationship. As a step towards understanding clients' perceptions, additional descriptions of their statements are made, and compliments help in affirming their perception. Though most of the time the client's perceptions are given affirmations, in a situation where the client expresses the feeling of hitting somebody or suicidal thoughts, the therapist uses education and confronts the client's thoughts and transforms them. The therapist asks the client about the details of the situation which is making them think that way. The elaboration helps the client relax and divert from hitting or suicide thoughts.

17) Natural Empathy: Natural Empathy implies having controlled emotional involvement. It is quite significant for the interviewer to be sensitive to the client's emotions, feelings, understand their meaning and respond appropriately. The principle of controlled emotional involvement as called by Biestek (1957) requires the therapist to communicate with the client both with feeling and thought. This principle is quite close to what is called empathy by others (Benjamin, 1987; Egan, 2010; Keefe, 1976). Empathy is like imaginatively entering the thinking and feeling the world of the client. According to Rogers (1957) empathy is "to sense the client's private world as if it were your own, but without ever losing the 'as if' quality and "to sense the client's anger, fear, or confusion without getting bound up in it" (Rogers, 1957, pp. 95-103). Lambert and Bergin have stated that everybody agrees that "accurate empathy, positive regard, non-possessive warmth, and congruence or genuineness" a must for "working alliance" between the client and therapist though the latest research is becoming ambiguous regarding this (Lambert & Bergin, 1994, pp. 143-189). The empathy of the practitioner is directly related to the client's report of satisfaction and progress but when this is measured with some other objective instrument like standardized tests etc. the picture is not that clear. Among solutions building approaches, the role of empathy has become a matter of debate. On one hand, some believe that the empathy and positive relation between the client and therapist gets a boost with empathy (Kiser, Piercy, & Lipchik, 1993; Lipchik, 1999; Lipchik, 2002), on the other hand, others believe that such conversations are not essential to make a

positive connection within the client and therapist (Miller & de Shazer, 2000). According to them one does not need to extract the emotions to build a working relationship as paying attention to one aspect may hinder the whole process. What is required is empathic affirmation i.e. listening carefully, echoing the keywords and summarising statements like “it seems that it is really tough time” and explore further by additional questions. The nods, respectful silence and compassionate tone are other ways of showing empathy.

18) Normalizing: Sometimes the problems of the client are such that they appear to be beyond the control and out of the boundary of normal life. Normalizing is wondering with the client whether these problems are out of the range of ordinary problems. It is like countering the deep-seated problems and reasons behind life’s expected challenges. Usually, this can be done by asking that whether the situation described is to be expected or not. For example, the practitioner may ask “Well, after all, they are parents! Parents get angry again and again”. This statement will make the youth realize that though he is annoyed with his parent’s response, parents can be angry, and this is quite normal. This will calm down the youth and make him understand the parent’s perspective. So, normalizing must be done and should be done naturally and confidently. It is a useful tool of solution building and helps in de-pathologies’ the difficulties and clarifying the goal.

19) Returning the Focus to the Client: Most of the time when the client comes for help, the focus is on problem description and talk about what they would like others to do differently to make the desired change. It appears as if they think themselves to be powerless in the situation and their well-being is at the mercy of others. For example, the youth may say “If my teacher would only stop talking to me. On some occasions, the teacher treats as if I’m a child”. The practitioner has to listen to these statements because they narrate the client’s perceptions and views at that particular moment but at the same realization that the client has to shift the focus to move from powerlessness feeling to the sense of empowerment. The client has to shift from what he dislikes in another person to what is required in that situation. So, the practitioner may rephrase the above sentence as “Suppose your teacher has come here and I have asked him what you could do differently to make it just a little easier for him not to talk down to you. What do you think he

would say?” (De Jong & Berg, 1998, p. 189). By asking the question this way, the practitioner makes the client shift focus from problem talk to solution talk and this is the essence of solution building.

20) Amplifying Solution Talk: Solution-focused conversation is a talk shared by the client and therapist in which they concentrate on the aspects of the life that the client wants to be different and how that change can be brought about. It is not easy to make the client shift from talking about problems to discussing the solution. Sometimes the client also shows resistance. The practitioner’s challenge lies in overcoming the reluctance and makes the client shift from problem to solution. Normally the practitioner invites the client to talk about the change in life after the solution to the problem. While talking about the difference, the client also narrates what he would be doing differently which the therapist will amplify with additional questions and clarify the new role in that desired situation. The solution talks give a hope to the client and make them confident about the new possibilities.

21) Grounding: Most of the time communication involves listening with an aim to reply and not understand. Grounding is listening and paying attention to minute details to understand. The dialogue between the participants helps build mutual understanding or “common ground” (Clark & Schaefer, 1987). It can be done in 3 steps:

- a) **The speaker says something or says some new information**
- b) **The practitioner gives proof of having understood the speaker**
- c) **The speaker confirms that the message has been understood correctly.**

For example, the therapist may present some information in the form of a question. The client displays that he/she has understood this by giving a meaningful answer. The therapist echoes the keywords to confirm that the message has been understood correctly. Grounding is a great tool of mutual understanding and the level of understanding is better than the level of understanding gained by simply witnessing the information (Schober & Clark, 1989). The listener indicates his/her understanding by following ways (Clark & Schaefer, 1989; Clark H. H., 1996):

- (i) By continue attending the speaker with eye contact, nodding etc.
- (ii) By giving a response which is non-interruptive like saying “mm-hmm” etc.
- (iii) By speaking in turns i.e. asking a question using the keyword from the last response.
- (iv) By giving appropriate responses like echoing or appropriate facial expressions to the response given. The best response indicating understanding can consist of a paraphrase or repetition of what was told (Clark H. H., 1996)

So, in the end, it can be said that listen, select and build are the essentials of solution-focused therapy. Echoing, paraphrasing and summarising help in attaining these goals. The stance of not knowing and leading from one step behind, along with echoing the client’s words with a changed tone or repeating the keywords help in reaching the goal of being solution focused. All this has a transforming effect and the client is able to see the solution which earlier was hidden and also help him involve in solution talk instead of problem talk. The efficient practitioner is a good listener, able to select the words to be echoed and builds upon the question with paraphrases such that the client is able to move in a solution-focused direction.

It can be concluded that the uniqueness of the solution-focused brief therapy lies in encouraging solution talk rather than problem talk as is true with most other therapies. The client comes out of the vicious circle of thinking about problems, problems, and problems to perceive the possible solution. The hope to find solution works like a miracle and help the client becoming confident enough to deal with day to day problems.

1.1.5 Relevance of SFBT in Indian setup.

The Indian citizen, though socialized in traditional values, was expected to change and adopt modern values. The discrepancy in older and new values termed as generation gap is reflected in the mental state of citizens. Now with the high paced movement towards the development and in a spirit to reduce the gap with the

developed World, the Indians were stressed. The stress led to many psychological problems and instead of developing the Indian methods of Yoga and Meditation to deal with these emerging problems, the Psychological methods of the West were imported which had a different base than the Indian basis (Gergen, Gulerce, Lock, & Mishra, 1996).

1.2 Indian therapeutic system

The Indian system depended on yoga and meditation for mental health. The challenge before the present therapist is to validate a therapy that is appropriate to the Indian scenario. It should cater to the needs of the variable cultures found in Indian society (Rao, Paranjpe, & Dalal, 2009). The principles of yoga have been found to be Universal and are being practiced all over the world. Practically, the modern society requires the old methods in changed forms that can be easily adapted to the present daily life and modified according to the ones belief system and cultural context. In other words, the present day therapy needs to understand the effect of traditional healing methods like visiting gurus, mystics, etc. (Kumar, Bhugra, & Singh, 2005); to analyze the relation between dowry and domestic violence (Rastogi & Therly, 2006), the cultural reasons behind adapting therapy to the socio-cultural system in accordance with existing classes (Paralikar, Agashe, & Weiss, 2004) and relevant issues in adapting western therapies to Indian contexts (Laungani, 2004).

So, the Indian society has its own problems. There is a conflict between the past beliefs and modern methods. The modern methods adopted were imported from the West and as such could not provide the expected effects. This realization requires the understanding of changing value system and belief system of the Indians and modifying the available methods in cultural contexts. Though the Indians were earlier very religious and believed in the concept of 'atman', the modern-day educated Indian is no longer satisfied with those explanations. The available therapies imported from the West are unable to understand the basic psychology of the Indian individual and so unable to solve the problem to that extent (Gupta & Rai, 2019)

In an endeavor to find the balance between the older religious solutions and the demands of the modern rational society, therapies like mindfulness, solution-focused brief therapy etc. are being developed.

1.2.1 Relevance of SFBT in India.

The use of SFBT is spreading fast. It has moved from lesser known to one of the popular approaches towards treatment in different countries. It is being widely used therapy for family counseling, mental health settings, social service environment, and child therapy, in prisons, schools, and hospitals (Miller, Hubble, & Duncan, 1996). Therapists have reported high success rates and satisfaction of clients with using SFBT.

The Indian system is highly conducive to SFBT. It can also be said that SFBT is the need of the hour in Indian system. The reason behind the relevance of SFBT in Indian scenario is that on one hand the high pace of development is leading to a rise in psychological health issues and on the other side, the scarcity of time and economic factors require a quick and solution-focused approach. The SFBT is also relevant from another perspective. India which has a population of 1.25 billion out of which almost 20% of people are below poverty without any health insurance for mental illness. Apart from this, less than 1 clinical psychologist is available per 1 million populations (Rehabilitation Council of India, 2015). All these reasons point to the growing need of a time and resources effective treatment. The brief therapeutic treatment models are very vital for present Indian clinical scenarios as they are quite economical and less time-consuming giving results in a short span of time.

1.3 Depression

Human beings are one of the best creations of Nature. They are different from other species because of some special abilities and emotional experiences and mood being one of them. These abilities make the person feel sometimes happy on some occasions and sad on other occasions. The emotional feelings also influence the perception of the environment. If the individual is happy, everything around seems to be very beautiful and full of life. On the other hand, if the individual is in a sad mood, everything around seems to be dull and worthless. In routine, each of the individual goes through these ups and downs of the mood without much problem. If some individual is not able to cope with these changes in a balanced way, then he/she may be having a mood disorder. The feelings of sadness, worthlessness accompanied by pessimism and lack of energy to do routine work is called depression. (Ray, 2015)

According to World Health Organization (WHO) “Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration” (Anon, 2017). The Oxford English Dictionary defines depression as “a mental condition characterized by feelings of severe despondency and dejection, typically also with feelings of inadequacy and guilt, often accompanied by a lack of energy and disturbance of appetite and sleep.” (depression | Definition of depression in English by Oxford Dictionaries, 2017).

Depression has been referred to since ancient times. The ancient Greek Philosophers Hippocrates, Galen, who was the first to treat mental disorders similar to physical ailments, also mentioned depression as melancholia. According to them, melancholia described the condition in which the person has feelings of worthlessness and guilt. The person feels dissatisfied with the life situation, finds difficulty in sleeping, is restless, irritable, finds difficulty in taking decisions and sometimes wishes to die. In depression the sad mood dominates and there is a lack of feelings of pleasure in anything the person does. Depression can be accompanied by loss of appetite and loss of weight.

1.3.1 Prevalence of Depression.

It is estimated that almost 322 million people were afflicted with depression in 2015 (World Health Organisation, 2017). The current prevalence was 2.68% or in other words, 1 out of 20 adults suffer/ have suffered from depression. More than 80% do not receive any treatment. 2 out of every three individuals with depression report disability in work (67.34 %), family life (70.2%) and social life (68.6 %). 21 % of affected people feel substantial difficulty in everyday chores. There are gender variation in the prevalence of depression. About 1 in 4 females and 1 in 10 males have experienced at least one major depressive episode (Rutter M. , 2006). Genetic studies show that depression is positively correlated with both genes and the environment (Rutter M., 2006). A research study with monkeys shows that genetic risks were increased with high or less responsive caretakers (Suomi, 1999).

Depression is attributed as the most common cause of non-lethal health loss. It accounts for “7.5% of global years lived with disability (YLLDs) and 2.0% of global

disability-adjusted life years (DALYs) in 2015” (WHO, 2017). It is estimated to be the second major reason behind burden due to disease all over the world and a third major cause of disease burden in LMIC (low-and middle-income countries) by 2030 (Mathers & Loncar, 2006). India is estimated to be having 57 million people affected with depression. India accounts for almost 15 % global DALYs to psychological and substance abuse problems (Charlson, Baxter, Cheng, Shidhaye, & Whiteford, 2016). It is expected that DALYs due to depression will rise roughly to 22.5% at the present rate of population growth and due to aging (Charlson, Baxter, Cheng, Shidhaye, & Whiteford, 2016). The globalization, urbanization, migration, and modernization are bringing rapid socio-demographic changes such that it is likely to increase the prevalence of depression in the coming time. The Indian NMHS (2015-16) report reflects that there are 1 in 20 (5.25%) people above the age of 18 years who have at least once suffered from depression (World Health Organisation, 2017). In comparison to the general population, the depressed person has 1.52 times more chances of dying (Cuijpers, et al., 2014).

Depression affects everybody from young to old, male and female, children and elderly, rich or poor etc. The prevalence rate of depression among adults in India varies from 1.8% (severe) to 39.6% (mild to Moderate) with early onset during early adulthood (Ferrari, et al., 2013; Charlson, Baxter, Cheng, Shidhaye, & Whiteford, 2016; Behera, et al., 2016; Rao, et al., 2014; Shidhaye, Gangale, & Patel, 2016; Mathias, et al., 2015; Kishore, Reddaiah, Kapoor, & Gill, 1996). Depression is found to have a high prevalence rate among women and 20-69 year adults in Indian studies (Charlson, Baxter, Cheng, Shidhaye, & Whiteford, 2016; Shidhaye, Gangale, & Patel, 2016; Mathias, et al., 2015; Deswal & Pawar, 2012). The reason for the higher prevalence in women are attributed to biological factors including hormonal imbalances along with social and financial reasons. Contrary to this, some studies have found no gender variations in depression (Kaur, 2014). Manjari (2016) studied depression level among college students and found that though there is no significant gender difference in the level of depression, female students are more depressed. Karmakar and Behera also found no significant gender differences but found the male to be more depressed. In an empirical study of depression among college students found no significant stream differences (Karmakar & Behera, 2017).

Karmakar and Behera (2017) also did not find any category differences (SC, ST, and OBC) or parental job differences.

So, depression from the given data can be inferred as one of the most common problems affecting the Indian population at large and college students in particular. College students are the future of the nation. Many studies have been carried out to study depression among college students. It has been found that students with depression have considerably low performance in social, vocational and educational fields (Field, Diego, Pelaez, Deeds, & Delgado, 2012). Depression among college is highly prevalent across the country. College students are at a stage of life where they are moving from childhood to adulthood. This transitory nature of their developmental stage makes them very sensitive. A college education is the foundation for their future life and is inseparable from the nation's progress. Many people have considered the importance of developing intervention techniques to help prevent or minimize mental health problems (Gjerde, 1993). Problems like depression can be a hurdle in the success in education or career of students (Avinson & McAlpine, 1992; Bhave & Nagpal, 2005).

Depression is becoming so common that WHO has addressed it as a leading public health problem of concern in India which is leading to disability on one hand and socio-economic losses on another hand (World Health Organisation, 2017). WHO slogan for 2017 World Health Day is "Depression-Let's Talk" reflecting the severity of the problem. Though on the surface depression is related to feelings of sadness, reduced interest in daily activities, and loss of energy or fatigue, at the deeper level it is also related to suicide.

Singh and Joshi (2008) studied the relationship between suicide ideation, depression, life stress, and personality and found that depression and suicide ideation were positively related. Another study conducted in Mangalore city found a higher prevalence of depression among pre-university students. Among pre-university students, more number of commerce stream students had depression as compared to science stream students. Male students of Government College were also found to be having slightly high levels of depression (Joseph, 2011). A study carried out to study mood disorders like depression and anxiety among the Tafiya Technical University students found that females had higher anxiety whereas males had higher depression

(Al-Qaisy, 2011). Significant differences between males and females on depression have also been reported by Sharma et al (2011). A research was conducted to study the presence of stress as an indicative sign of depression in students studying in the last semester of a nursing undergraduate degree course. They found that of the 88 participants, 76.9% had medium stress levels. They also found a relation between the stress and depression symptoms (Moreira & Furegato, 2013).

So, depression is one of the most common problems of college students. Let us see the relationship between college students and depression and elaborate on its symptoms and causes.

1.3.2 Depression and College Students.

College life is the most exciting part of life. College life is associated with memories of fun and excitement. But there are some circumstances which may make college students feel negative and lead to depression. College is also a synonym for independence and being away from home. This separation from family and learning to live with responsibility though mostly dealt with may lead to feelings of hopelessness and despair in some students.

If any student is sad, irritable or pessimistic for more than 2 weeks, then he/she may be depressed. It is a common problem faced by college students.

Depression is:

- Health problem
- Treatable
- Common problem
- Cured earlier it is diagnosed and attended
- Accompanied by feelings of worthlessness and sadness
- State of irritability that can affect normal life

Along with biological, psychological and sociological causes of depression, the following are the causes of depression in college students:

- Genetic or hereditary
- Divorce, broken love affairs, family problems, and relationship problems.
- Financial problems
- Studies and job-related stress

- The increased stress due to rising emphasis on marks attained in the examination. (Vedas Cure, 2015)

1.3.3 Types of Depression.

Depression varies from mild, moderate to severe. The mild and moderate forms of depression often go undetected as they require good listening and observation skills to assess them. Along with this the comorbidity of symptoms with other disorders makes it even more difficult to identify them. The severe forms are mostly reported as the condition makes it difficult to continue with the routine schedules and also leads to suicidal thoughts and tendencies.

Depression is manifested in the following ways:

- Depression among children is manifested as feelings of sadness, complaints of stomach ache, headache, etc. feelings of boredom, irrational fear or anxiousness, poor results and disturbed relationships.
- Adults show the depressive sign in their work performance, which is lowered than usual, they show a change in their functioning levels which is accompanied by thoughts of suicide.
- The elderly manifest depression in the form of psychomotor agitation and irritableness. They may also report somatic complaints along with poor appetite.

So, in this way the symptoms of depression show variation with age, making it more difficult to be recognized by family, friends, and relatives. The symptoms of depression have also been found to have cultural, social, and psychological aspects that are not taken into consideration in the traditional medical care also. For example, the slums of urban areas, the women show poor mental health frequently in gynecological concerns. (Maitra, et al., 2015).

1.3.4 Etiology of Depression.

Depressions or feeling of being low in layman language has many variants and every variant has a different cause. The cause ranges from a seasonal change to loss of a loved one; missing a chance to accomplish one's goal to losing hope for the same. So,

the causes of depression are manifold and hence are usually categorized as biological, psychological and social-cultural.

1. Biological: Human behavior is affected by the neurochemical factors and any imbalance or irregular activity can lead to behavioral problems. The causes related to the chemical, genetic or physiological aspects of human system are categorized under this head. They can be classified as:

- i. **Genetic:** The genes are the building blocks of human beings. The basic physiological and constitutional aspects are determined the genetic combination one has. To study the relationship of genes with depression, family studies, twin studies, etc. are done. In other words, the comorbidity of depression in the relatives of the individual having disorder i.e. proband are studied. It has been found that the relatives of the probands have 2 to 3 times greater presence of depression in comparison to control group's relatives who do not have a mood disorder (Lau & Eley, 2010; Klien, Lewinsohn, Rohde, Seeley, & Durbin, 2002; Levinson, 2009); more the severity, earlier onset, or recurrence in the proband, higher is the rate of depression among relatives (Kendler, Gatz, Gardner, & Pederson, 2007; Klien, Lewinsohn, Rohde, Seeley, & Durbin, 2002; Weissman, et al., 2005).

Twin studies are another source of determining the effect of genes in depression. Here the frequency of occurrence of depression is compared on the basis of data obtained from identical twins and fraternal twins. Studies direct towards heritable nature of mood disorders. An identical twin as compared to fraternal twin is likely to have mood disorder 2 to 3 times more especially if the first twin is diagnosed with mood disorder (Kendler, Neale, Kessler, Heath, & Eaves, 1993; McGuffin, et al., 2003; Kendler, Aggen, & Neale, 2013).

Gender differences have also been reported in depression. Among women, depression is more heritable (Bierut, et al., 1999) but among men, depression has more of environmental roots (Lyons, et al., 1998).

- ii. **Neurotransmitter Systems:** Neurotransmitters play a significant role in human demeanor. Variations in levels of some neurotransmitters have been found to be responsible for the mood disorders. For example, low level of serotonin (Thase, 2005; 2009); Stress lowers dopamine level leading depressive behavior (Thase, 2009). On the other hand, some research concludes that the role of serotonin is to regulate emotional reactions by affecting the system that involves nor epinephrine and dopamine. The ‘permissive hypothesis’ states that “when the serotonin levels are low, other neurotransmitters get permission to vary widely and this deregulation contributes to irregularity in mood including depression.” So, drop in norepinephrine may be the consequence. (Barlow & Durand, 2015). Presently the pendulum swings towards the balance of neurotransmitters rather than the role of anyone neurotransmitter (Carver, Johnson, & Joormann, 2009; Whisman, Johnson, & Smolen, 2011; Yatham, et al., 2012)
 - iii. **Endocrine system:** It has been observed that people suffering from hormonal disorders experience depression (hypothyroidism or Cushing disease leads to excessive cortisol and feeling of depression and anxiety) (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Britton & Rauch, 2009; Charney & Drevets, 2002).
 - iv. **Sleep and Circadian Rhythms:** The individuals with depression report sleep disturbances. Depressed patients have been found to enter REM sleep quickly and experience intense REM activity, but the slow-wave sleep or deepest sleep occurs with great difficulty (Jindal, et al., 2002; Kupfer, 1995; Thase, 2009). Some sleep features have been found to be present only during the depression (Riemann, Berger, & Voderholzer, 2001; Rush, et al., 1986).
2. **Psychological Factors:** Along with the biological, psychological factors have been found to be important aspect of depression. Some psychological factors are:
- a. **Stress:** Most of the psychological problems have stress behind them. Similarly, for depression, stress has been found to be one of the root

causes. The common stress-related issues reported change or leaving the job, divorce, family quarrels, or career-related tensions etc. though it is difficult to ascertain the major reason (Carter & Garber, 2011; Hammen, 2005; Hammen & Kean-Miller, 2013). Lot of research has led to a conclusion that stressful life experiences are linked to mood disorders (Hammen, 2005; Grant, Compass, Thurm, McMohan, & Gipson, 2004; Kendler & Gardner, 2010; Monroe & Reid, 2009); the context of life event has a significant relationship between the severity of the event and the onset of depression (Brown G. W., Depression, 1989a; Brown, Harris, & Hepworth, 1994; Kendler, Karkowski, & Prescott, 1999b; Mazure, 1998); Breakup in a relationship is more an important factor for adolescent (Carter & Garber, 2011; Monroe, Rohde, Seeley, & Lewinsohn, 1999) and adult (Kendler, Hettema, Butera, Gardner, & Prescott, 2003); it is confirmed that loss, the experience of social rejection and facing humiliation are significant stressful life events and lead to depression (Monroe, Slavich, & Georgiades, 2009).

- ii. **Learned Helplessness:** Seligman's observation of the emotional reaction of dogs and rats to the situation they do not have any control gave definition to the concept of learned helplessness (Seligman, 1975). Studies have found that individuals are prone to become anxious and depressed when they realize that they do not have much control over the events in their lives (Abramson, Seligman, & Teasdale, 1978; Miller & Norman, 1979). Anxiety is the first reaction and depression follow when there is hopelessness regarding coping with stress (Barlow, 1988; Barlow, 2002). The attribution style in depression is internal, stable and global. Negative cognitive style almost always precedes depression (Alloy & Abramson, 2006; Garber & Carter, 2006; Garber, et al., 2009). Negative attributions are not only related to depression but also anxiety (Barlow, 2002; Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Hankin & Abramson, 2001). Abramson, Metalsky, and Alloy (1989) reexamined the learned helplessness theory to replace negative

attribution with lack of hopelessness as a cause of depression (Alloy & Abramson, 2006; Barlow, 2002; Chorpita & Barlow, 1998).

- iii. **Negative Cognitive Style:** Negative interpretation of everyday events may lead to depression (Beck, 1967; Beck, 1976). Arbitrary inference, i.e. making a negative inference and not the positive interpretation of the situation and overgeneralization, i.e. one failure is considered as failure of self, are the two examples of negative cognitive style. This makes the person think negative about him/her, his/her present and future which together is a type of depressive cognitive triad. Negative schema is another dimension of cognition which leads to depression. The cognitive theory has gained support from different studies (Gotlib & Joorman, 2010; Hammen & Kean-Miller, 2013; Ingram, Miranda, & Segal, 2006), depressed individuals cognition is more negative than non-depressed (Gotlib & Abramson, 1999; Joormann, 2009); depressed individuals recall negative memories more than normal individuals (Gotlib, Roberts, & Gilboa, 1996; Joormann, 2009)

3. Social and Cultural Dimensions: Social and Cultural factors play a vital role in the onset of depression. Some of these are:

- i. **Marital Relations:** Dissatisfaction in the marital relations is related to depression (Davila, Stroud, & Starr, 2009). Bruce and Kim (1992) on the basis of their research concluded that marital split causes depression and men faced more risk of depression immediately after the split (Bruce & Kim, 1992).
- ii. **Depression in Women:** Studies have gender imbalances in the prevalence of depression. All over the world, the rates of depression may be different but almost everywhere women are almost 70 percent more prone to depression (Kessler & Bromet, 2013; Seedat, et al., 2009; Weissman & Olfson, 1995). The reason behind the gender differences can be attributed to socio-cultural factors which lead to feelings of uncontrollability and helplessness in females (Barlow, 1988; Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Cyranowski, Frank, Young, & Shear, 2000; Hankin & Abramson, 2001). On the

other hand, men do not ruminate over the past and distracting the attention keeps them busy with day to day activities. This lowers their chances of developing mood disorder or depression (Addis, 2008; Dimidjian, Martell, Herman-Dunn, & Hubley, 2014; Jacobson, Martell, & Dimidjian, 2001).

- iii. **Social Support:** Social factors are quite important in depression (Beach, Jones, & Franklin, 2009). Individuals living alone have more chances of developing depression (Pulkki-Raback, et al., 2012). The importance of social support in depression was first suggested by Brown and Harris in 1978 and later supported by many other studies (Brown & Harris, 1978; Joiner, 1997; Kendler, Kuhn, Vittum, Prescott, & Riley, 2005; Monroe, Slavich, & Georgiades, 2009).

1.4 Anxiety

The word anxiety is derived from the Latin root “anxietas” i.e. to stifle, agitate, and feel inconvenience and throttle. Anxiety is implied to a behavior in which feelings and reactions to threat dominate. Anxiety is a feeling of uneasiness or nervousness. In other words, a constant state of worry can be called anxiety. American Psychological Association defines “Anxiety is an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure. People with anxiety disorder have recurring thoughts and have a tendency to avoid certain situations” (Anxiety, 2019). It can be said that anxiety becomes neurotic anxiety when the feelings of fear get stretched to all the life situations without any control.

The Diagnostic and Statistical Manual 5 (DSM-5), a classification manual of mental disorders by the American Psychiatric Association, 2013 lays down the following criteria to diagnose generalized anxiety disorder:

1. The behavior includes excessive anxiety or worrying about day to day activities or tasks. This behavior pattern is present for at least 6 months and can be called excessive.

2. The constant worry is difficult or beyond the individual's control. Though the worry may change from one topic to another, it is almost always present.
3. The worrying behavior is "associated with at least three of the following symptoms- restlessness, fatigue, impaired concentration, irritability, increase in complaints of aches or changes or difficulty in sleeping" (American Psychiatric Association, 2013).

1.4.1 Effect of Anxiety.

The feelings in the anxious state are not pleasant yet almost everybody experiences anxiety at one or the other time. Is anxiety always harmful? The answer is no it does have some beneficial effects if the levels are moderate. Yerkes and Dodson, (1908) concluded that people are able to prepare for the upcoming exams, interview or any other engagement just because of some optimum amount of anxiety (Yerkes & Dodson, 1908). Anxiety was called "shadow of intelligence" as anxiety is in a way found necessary to connect to the future task. In other words, anxiety is a feeling of fear of something going wrong. When a person is planning for some event or task, the fear of something going wrong makes him/ her conscious and better prepared for the same (Liddel, 1949). But this does not mean that anxiety is always good. Too much anxiety or fearing the consequences of any activity makes it difficult to concentrate on the present task, thus making it difficult to give ones' best. High anxiety gives rise to the feeling of stomach sickness or leads to perspiration in palms and soles and inability to think logically. The constant fear or anxiety makes it difficult to continue daily routine activities smoothly and may even affect personal or professional relationships. Anxiety includes negative thoughts with anticipated danger or threat as the center. It has been found that attention is one personal attribute that makes a person prone to anxiety disorder. People who are very sensitive to cues related to future danger are more prone to worry excessively and panic (MacLeod, Rutherford, Campbell, Ebsworthy, & Holker, 2002; Teachman, Smith-Janik, & Saporito, 2007). Such individuals have a tendency to attend vigilantly to every sign of danger especially when they are under stress. The apprehension of danger triggers maladaptive and self-perpetuating thinking pattern which can turn out of control

resulting in the vicious cycle of uncontrolled fear. The threatening state that results from this situation is stored in the memory like schemas and is easily reactivated by related cues. Once the individual attends to any threatening cue, the efforts to adapt or solve the problems are disrupted and results in the repetitive sequence of behavior in which the individual rehearses the expected threat and finds out a way to avoid them. This process also leads to “what if” questions that ultimately lead to an increase in negative emotions (McLaughlin, Borkovec, & Sibrava, 2007; Oltmanns & Emery, 2012).

1.4.2 Anxiety among College Students.

The breakdown of Indian traditional system, values and transitional nature of social structure underlies the incidence of high anxiety among Indian students (Sinha, 1962). Above normal/high anxiety and depression effect academic performance of students and this, in turn, affects the economy of the nation. A study done to examine the anxiety related to exams in first-year medical students found that 8.67% had mild anxiety, 8.9% moderate anxiety and 4.4% severe anxiety levels. This study found a significant gender difference in anxiety. Female students were more anxious than their counterparts (Prabha, Parkash, Ravi, & Vijaynath, 2017). Anxiety effects the performance of students particularly during the examination it is responsible for the large gap between potential and actual achievement. Parkash and Hooda conducted research to study the relationship between anxiety and sex, locality; stress and academic achievement among senior secondary school students. From the study of a sample of 300 males and females from Sirsa, Haryana, it was revealed that anxiety of arts and science stream differed significantly and that of arts and commerce stream was also significantly distinct (Parkash & Hooda, 2016). The main reason behind high anxiety level can be attributed to the pressure to do better and achieve high goals. Anxiety and depression have also been found to be high in nursing students of Kolkata (Basu, Sinha, Ahamed, Chatterjee, & Misra, 2016).

1.4.3 Etiology of anxiety.

Anxiety or the constant feeling of fear of something going wrong has its roots in all the three aspects of development i.e. biological, psychological and social. Each one of these is discussed below:

- 1. Biological Factors:** Different research studies have concluded that tendency to be tense or anxiety has some genetic basis (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Clark L. A., 2005; Eysenck, 1967; Gray & McNaughton, *The neuropsychology of anxiety: Reprise.*, 1996). The genetic factor does not lead to disorder on its own. A genetic vulnerability becomes a disorder when other psychological and stress factors like stress, environment, etc. work along (Gelernter & Stein, 2009; Kendler, 2006; Owens, et al., 2012; Rutter, Moffit, & Caspi, 2006; Smoller, Blocks, & Young, 2009). The biological reasons for anxiety also include the role of gamma-aminobutyric acid (GABA) depletion and noradrenergic system (Hermans, et al., 2011); serotonergic neurotransmitter system (Stein, Schork, & Gelernter, 2007); the latest view focuses on corticotrophin-releasing factor (CRF) relationship with anxiety and depression with a gene group getting activated and turning on the system (Essex, Klein, J., Goldsmith, & Kalin, 2010; Heim & Nemeroff, 1999; Khan, King, Abelson, & Liberzon, 2009; Smoller, Yamaki, & Fagerness, 2005). The CRF is found to activate the hypo thalami-pituitary-adrenocortical (HPA) axis which has an effect on the areas of the brain which are related to anxiety i.e. hippocampus and amygdale etc. The CRF system is closely related to GABA-benzodiazepine system along with serotonergic and noradrenergic neurotransmitter systems. The brain area which is generally linked to anxiety is the limbic system which is like a interconnection between cortex and brain stem (Britton & Rauch, 2009; Gray & McNaughton, 1996; Hermans, et al., 2011; LeDoux, 2002). The behavioral inhibition system (BIS), as explained by Gray on the basis of the studies on the limbic system of animals, is activated when there are any unexpected events. In other words, perception of any danger in the immediate environment activates BIS leading to freezing and experiencing anxiety leading to an evaluation of the situation to confirm danger (Gray, 1985; McNaughton & Gray, 2000). Several studies have indicated that the environment can influence the sensitivity of the brain circuits leading to anxiety or anxiety disorders (Francis, Diorio, Plotsky, & Meaney, 2002; Stein, Schork, & Gelernter, 2007). Cigarette smoking in teenage has been

found to lead to an increased risk of smoking in adulthood. The possible reason behind this may be that the nicotine, an addictive drug leads to respiratory and somatic problems also triggers anxiety or panic and increase vulnerability to anxiety disorders (Feldner, et al., 2009; Zvolensky & Bernstein, 2005). Brain imaging technique has lend further support to Gray's behavioral inhibition system (Ellard, 2013; Britton & Rauch, 2009; Ochsner, et al., 2009); the relationship between the limbic system and anxiety include the role of amygdala's increased sensitivity to stimulation i.e. abnormal bottom-up processing and lower the activity of cortex that decreases the regulation of hyperactive amygdala i.e. abnormal top-down processing (Britton & Rauch, 2009; Shin & Liberzon, 2010).

2. **Psychological Factors:** The psychologists of different schools of thought have given different viewpoints regarding the psychological causes of anxiety. Freud explained anxiety as a response to the danger present in the situation which is like infantile fearful situation. Behavioral psychologists explained anxiety as learned patterns of behavior through conditioning, imitation or modeling, etc. (Bandura, 1986). Recent research favors an integrated model including different psychological factors as a model of anxiety (Barlow, 2002; Suarez, Bennet, Goldstein, & Barlow, 2008). The main reason behind anxiety is a feeling of losing control of things happening around which has its roots in childhood where the control is very less (Chorpita & Barlow, 1998) and may take the form of full confidence or total uncertainty in adulthood. If the feelings of uncertainty dominate then the person is always worrying about something wrong that may happen and shows a sense of uncontrollability. Such behavior develops due to parental behavior, upbringing and other environmental factors (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Bowlby, 1980; Chorpita & Barlow, 1998; Gunnar & Fisher, 2006). The parents are like role models to their children. Children brought up in homes where parents respond to their needs and provide a secure environment for independent movement and exploration for the development of the child's personality, have healthy personalities (Chorpita & Barlow, 1998). On the other hand, the children who are brought

up by overprotective parents making way for them and not letting them explore their environment are unable to develop ways to cope with their environment (Barlow, 2002; Chorpita & Barlow, 1998; Dan, Sago-Schwartz, Bar-haim, & Eshel, 2011; White, Brown, Somers, & Barlow, 2006; Gunnar & Fisher, 2006). So, the better the confidence level, the lesser are the chances of developing anxiety.

3. **Social Factors:** The stress from the social or psychological basis is the main reason behind anxiety. So, the reasons for anxiety can be marriage, work environment, social rules, and regulations, etc.

So, the factors of anxiety can be summed up as triple vulnerability theory of anxiety development (Barlow, 2002; Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014; Brown & Naragon-Gainey, 2013). The three vulnerabilities are generalized biological vulnerability which is present as genes but not sufficient cause of anxiety; generalized psychological vulnerability when the upbringings instill feelings of insecurity and unable to develop belief of control in a person, then it can be a reason for anxiety; specific psychological vulnerability is when the anxiety is situation-specific and affects behavior in a particular situation or presence of some stimuli. The vulnerabilities can be depicted as follows:

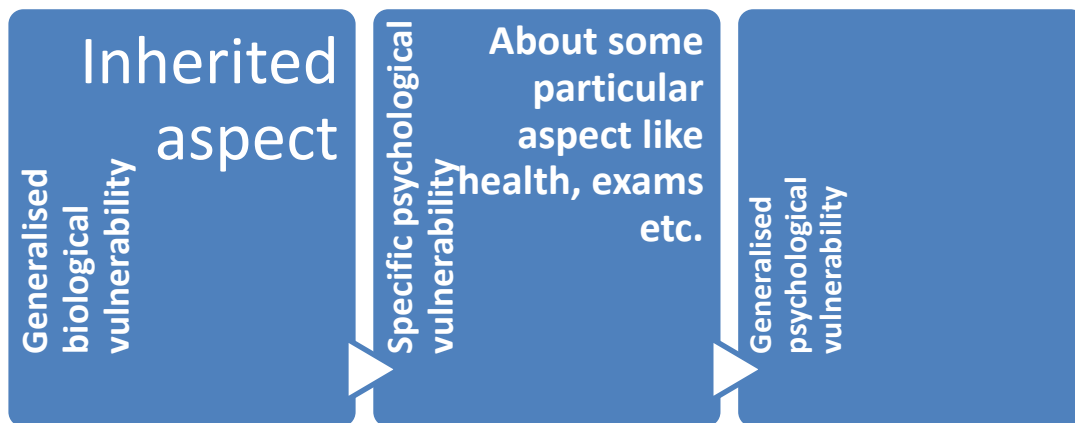


Figure 1.3 Showing the triple vulnerability of anxiety

1.4.4 Conclusion for anxiety and depression causes.

So, the review of the causes of anxiety and depression reflect that both of them share genetic vulnerability (Barlow, 2002) that acts as a neurobiological pattern of

responding to stressful situations. Individuals', who are prone to depression, anxiety or both, experience feelings of inability to face the situation (Barlow, 2002; Chorpita & Barlow, 1998). The reactions to stressful situations range from full confidence to inability to face the situation. The individuals' who are prone develop a pessimistic style of cognition leading to giving up and depression (Alloy L., et al., 2000; Alloy & Abramson, 2006). So, genetic and psychological vulnerabilities have been found to be closely associated (Whisman, Johnson, & Smolen, 2011; Jenness, Hankin, Abela, Young, & Smolen, 2011). Research from time to time has found support or evidence for the assumption that depression and anxiety are closely related- more the anxiety, more is the depression in the proband and his/her kinsperson and progeny (Hudson, et al., 2003; Barlow, 2002) (Leyfer & Brown, 2011); anxiety and depression have common genetic factors (Kendler, Heath, Martin, & Eaves, 1987; Kendler, Neale, Kessler, Heath, & Eaves, 1992b; Kendler, et al., 1995). Barlow et al (2013) suggested that the genes are responsible for general biological vulnerability for mood disorders and not specific disorders. The type of disorder depends on the social, psychological or other biological factors (Kilpatrick, et al., 2007; Rutter M., 2010)

1.5 College students

Education is an inseparable part of each individual. Every country has its own education system. The Indian education system has transformed from "gurukul" system to the present 10+2 system. This system is followed by all the educational institutes located in the Indian Territory. Broadly the said system goes through the following stages:

- 1. Pre-Primary stage-** It includes the education imparted to the 3-6 year-old through kindergarten, play way schools, etc.
- 2. The Primary Stage-** It includes the educational institutes providing education to 5-12-year old and includes classes from 1st to 5th.
- 3. The Middle Stage-** The classes taught in the middle school include 6th to 8th class and 12- 14-year students are taught.
- 4. The Secondary Stage-** It starts with the class 9th and continues till 10th class and students at this stage are aged between 14 to 16 years.

5. Senior Secondary Stage- This stage includes the classes 11th and 12th in which students of age 16-18 years study.

6. Undergraduate Stage or College Level- the College imparts different degree programs varying from 3-4 years duration. Students begin college education at the age of 18 years. Almost 88 percent of graduation is completed by the youth in the colleges in India. (Levels or Stages of Education in India today)

The number of students in colleges is increasing with the spread of education and an increase in population. The AISHE report of 2015-16 shows that in India there are 39071 colleges. In those colleges, almost 2, 74, 20,450 students are enrolled at the undergraduate level. In other words, almost 79.3% of students are enrolled at the undergraduate level. In Punjab, there are 1050 colleges with an average enrolment of 633 per college. There are 6,11,747 students registered at the undergraduate level in Punjab. The total number of students admitted at the undergraduate level in the regular mode is 5, 92,455 in Punjab (Development, 2016). The students in the college are between 18-22 years of age.

The individual in the 18-22 years of age is called emerging adult by Arnett, professor of psychology at Clark University in his book “Emerging Adulthood: The Winding Road from the Late Teens Through the Twenties” (Arnett J. J., 2004). Jeffrey Jensen Arnett started his research in 1995. On the basis of interviews of 300 individuals in the age group 18 years to 29 years from different cities in about five years, on the question about what they wanted out of life he concluded that in spite of social and economic variations, almost all the youngsters gave similar answers. All of them felt a state of being in between. On the one hand, they were pulling out of adolescence, on the other hand were having a feeling of being responsible and at the same time being close and dependent on parents and family (Arnett J. J., 2004).

The fact that surprised Arnett was that they were still pondering over their identity. It is generally thought that the adolescents resolve the identity crisis before entering youth. But the Arnett’s youth had not settled their identity.

On the basis of his research outcomes, Arnett proposed “emerging adulthood” as a new stage of life development. The emerging adulthood has been described as “a time

from the end of adolescence to the beginning of young adult” when the individual is ready to take responsibility for job, family and parenthood.

In his APA book claimed that this phenomenon of an emerging adult has emerged in the last few decades due to social and economic changes (Arnett & Tanner, 2006).

1.5.1 Features of emerging adults.

Arnett has talked about five features of emerging adults:

1. **Identity exploration:** The emerging youth can be characterized as the age of identity exploration as this is the stage where the young person decides who he/she is and what are their motives behind work, studies, and romance.
2. **Instability:** This age can also be described as an age of instability. After schooling and graduation there are frequent changes in place of residence, romantic partner, etc. and get established by 30's only.
3. **Self-focus:** Another characteristic feature of this stage is increased self-focus. It is during this stage that independence is attained from the routines of the school, college etc. and time management is done with little freedom. Even after this, the choice is limited by the family responsibilities. So, it is the stage where the emerging youth can do some self-focus.
4. **Feeling in between:** At this stage, the common feeling among the emerging youth is the feeling in between. They find themselves at the border of an adult. Though they think that they are quite responsible yet do not feel very mature. They are apprehensive of their abilities and unable to take important decisions. On some occasions they feel that they are grown up but on other occasions want the assistance of elders.
5. **Possibilities:** Emerging adults are very optimistic. They feel that they can have better lifestyle and relationships than their parents. So, in a way the hope or the expectation of the range of possibilities makes this stage different from other stages.

Arnett observed that almost all the emerging adults have a lot of expectations from life. They feel that they will get a well-paid job and develop deep and long-lasting relationships. On the contrary, it is seen that the employers are always looking for

hard working employees and the ever-increasing divorce rate reflects the type of bonding between the married partners.

In this way there is a lot of difference between the expectation and reality. According to Arnett, if happiness is measured as gap in what you expect and what you get, then the emerging adults have to settle with unhappiness because of a wide gap between what they think and what they get.

Another evidence of the emergence of emerging adults as a new stage in life span development is the increase in average age of marriage. Arnett observed that in 50 years the average marriage age has increased from 22 to 28 for men and 20 to 24 for women in America. According to him, the increase in number of young people attending higher educational institutes has led to an increased time period between adolescence and adulthood. As compared to earlier times, more youth is going for higher education and even women want to settle their career before settling into family life. All this has led to a change in the stages of development.

Another index of emerging adulthood according to Arnett is heterogeneity. The variety of paths available and the different level of success attained by them display the heterogeneity of their life. Arnett also feels the need to support and guide them at the social level to help them do their best. He feels they are self-aware and willing to adjust to the demands of the time. The only thing that can help them reveal inner strengths is resources and guidance.

The focus on the emerging adults who succeed or those who struggle can help in knowing how successful transitions can be aimed at. Tanner opines that the heterogeneity talked by Arnett may have been developed by the foundation laid in childhood and adolescence period. The more the balance between adolescent's demand for independence and social and parents support, the better will be the transition from young adulthood to adulthood. Tanner also feels that young individual who is not equipped for adult role has to pay high costs.

In this way, with the spread of education, more and more individuals are going for higher studies. The period of student life has increased leading to emergence of new stage that can be called emerging adulthood. This stage is more mature than the adolescence but at the same less independent than the adults. They are facing transition from being dependent to being responsible. (Munsey, 2006)

This shift in age of independence is seen in almost all the parts of the world. Even in India, where child marriage was prevalent at some period of time, the age of marriage has increased. The census of 2011 data shows that the male mean age of marriage is 23.5 in 2011 as compared to 22.6 in 2001. Similarly, for females the median age for marriage has risen from 18.2 years in 2001 to 19.2 in 2011. According to S.S. Jodhka, Professor of Sociology at Jawaharlal Nehru University, the reasons that can be attributed for this change are increasing mobility and migratory nature of life due to work opportunities in the country. According to him, the focus of people is shifting towards earning a livelihood and that compels them to move from hometown. Another reason that can be held responsible for increase in median age of marriage is higher school enrolments. The economic and social development has increased the need for education. More and more students are getting enrolled in the schools and pursuing higher education. This leads to shifting of marital age.

1.5.2 Development.

Development can be defined as series of changes due to maturation and interaction with environment or experience (Hurlock, 1981). Van del Daele considered development to be a qualitative change i.e. a change not merely by addition of inches but a change which is quite complex and integrates many structures and functions (Van den Daele & L.D., 1976).

1.5.3 Goals of Developmental Changes.

The goal of the different changes taking place is to adapt to the environment. The process of adaptation requires the knowledge of self-i.e. self-realization or self-actualization. The goal is like an urge which is never static and requires the exploration of one's inner strengths. The urge is expressed on the basis of innate abilities and skills attained during the different stages of life. The urge in interaction with social obligations pressurizes the individual and one has to reach the goal by balancing the both. In the process, healthy environment providing ample opportunities to express inner abilities along with fulfilling the expectations of the society is required. If such an environment is not available and the individual's inner desires are repressed, then he may turn hostile towards the society giving rise to frustrations and other behavioral problems.

1.5.4 Stages of Development in the Life Span.

Life span of the individual can be divided into different stages. Each stage has its own characteristic features. The life span can be generally divided into the following stages:

- i. Prenatal period:** from conception to birth
- ii. Infancy:** from birth to second week
- iii. Babyhood:** from the end of second week to end of second year
- iv. Early childhood:** from 2-6 years
- v. Late childhood:** from 6-10 years
- vi. Puberty or Preadolescence:** from 10-12 years
- vii. Adolescence:** from 13-18 years
- viii. Early adulthood:** from 18-40 years
- ix. Middle age:** from 40-60 years
- x. Old age:** from 60 years to till death

(From Hurlock (1981), page 14)

There are different tasks for each stage during the life span. The college students are at the stage of early adulthood. According to Havinghurst, the developmental tasks during early adulthood include:

- i.** Starting a job
- ii.** Getting married
- iii.** Learning to live in heterosexual relationship
- iv.** Starting family
- v.** Bringing up offspring
- vi.** Taking up the responsibility of house
- vii.** Taking social responsibility
- viii.** Finding appropriate social group

Nowadays due to spread of education and need for higher qualification, the young adulthood can be further subdivided into emerging adult and early adulthood.

1.5.5 Characteristic features of College Students.

Earlier it was believed that once the individual reaches legal adulthood, he/she should become independent. The male should be ready to take the financial responsibilities

and the females should be prepared to take up household duties. With urbanization, the viewpoint changed, and it was believed that settling down too early leads to dissatisfaction. Today, at the age of 18-23 years, individuals are still students. Most of the time, they are financially dependent on parents and experience different relationships before finally settling down. This has increased the average age of settling down and the college students are not at the stage of settling but are at the stage of exploring different options available to them.

1.5.6 Settling-down Age.

Earlier it was believed that once the individual reaches legal adulthood, he/she should become independent. The male should be ready to take the financial responsibilities and the females should be prepared to take up household duties. With urbanization, the viewpoint changed, and it was believed that settling down too early leads to dissatisfaction. Today, at the age of 18-23 years, individuals are still students. Most of the time, they are financially dependent on parents and experience different relationships before finally settling down. This has increased the average age of settling down. The college students are not at the stage of settling but are at the stage of exploring different options available to them. So, today's college students can be called emerging adults than young adults.

1.5.7 Reproductive age.

In earlier times, when the marriage was done during adolescence, the early adulthood used to be a beginning of parenthood. In the present times, this no longer holds true. The modern times pay more focus on completing education and acquiring job. So, again the present college student age can be more appropriately called emerging adults in spite of young adults.

1.5.8 Problem age.

With beginning of 18 years of age, the individual is legally adult. The law gives them right to vote and gives the right to marry females. This independence brings many responsibilities with itself. It requires adjustment to newly got job and also to newlywed family life. As both the tasks are time and energy consuming so, it is a big challenge for this age. The parents are reluctant to offer help and come forward only

when the help is anticipated by the young people. Today, youth is not prepared to take up these responsibilities independently. So, again the challenge of present-day youth is different from the earlier day youth, it is better to call them emerging adults than young adults.

1.5.9 Stage of dependency.

Although the age of 18 years marks the beginning of legal adult age, but yet the young adult is dependent on their parents, family or society. This is truer in present times where this age marks a beginning of higher education and not the end of education. Being legal adults, they desire autonomy, but the financial dependence does not let them exercise their will. So, in this way this age is continuation of stage of dependency.

1.5.10 It is stage of change in values.

The movement from adolescence to early adulthood also marks a change from childhood notions to more rational viewpoints. At this age, there is radical change in pattern of thinking. The school child who does not like school at all may start believing it to be of great importance because the value of early education is understood and accepted at this age. The thinking pattern is more mature than the previous stage.

1.5.11 It is a stage of creativity.

With the attainment of legal adulthood, the young adults are more self-accepting and express their uniqueness in creative ways. They are no longer forced to conform to group norms and take pride in being unique. They are more rational and confident, express their talent and enjoy taking up jobs related to their hobbies that are enjoying as well as satisfying. The maximised strength, motor skills, mental efficiency along with motivation proves to be of great advantage in reaching the goals of this stage.

1.5.12 Interest transitions.

The interests being explored during adolescence settle down and are narrowed down by the time one reaches college. The higher education requires more awareness and efforts leaving little time for the other activities. So, the college students' life revolves

around preparing for the vocation of interest and the entertaining activities, though not forgotten, take a back seat.

1.5.13 Acceptance of self.

Entering the age of legal maturity, the young adults learn to accept their adult physique. Knowing the importance of physical attractiveness, they tend to devote extra effort on self-grooming. They practice their skills of good interpersonal communication and develop good social relationships. The college students are seen sitting together in groups and interacting with each other. They are more empathetic towards their peer group problems and try to solve them jointly. They have few intimate friends with whom they share their deep feelings. They are closer to friends than family. Clothes play a vital role. Clothes not only decide their physical appearance but are also symbol of social status, financial status etc.

1.5.14 Hazards to development during early adulthood.

There are many challenges in front of young adults in the age group of 18-23 years. They enter college where there is more independence as compared to school environment. The newly founded independence is on the one hand cherished but poses new challenges. It is easy to meet the challenges if the adequate foundation has been laid down. On the other hand, if the foundation is not strong enough, then it is difficult making the adjustments. If there is any type of physical health issue or defect, then it may prevent the individual to explore all the available options and master the future required skills. Another problem that can be hazardous is lack of appropriate training. If the previous bringing up incorporates proper training for the required skills, then the person is able to adjust to the new environment relatively easily otherwise may prove to be ill prepared. The overprotection at home also takes away the opportunities to develop appropriate skills. So, in the end we can say that the acquisition of proper skills and training in early periods of life is like tool that helps in framing proper and realistic goals that determine the success in life.

CHAPTER 2

REVIEW OF LITERATURE

“...we have seen almost 30 years of research, including basic research from communication laboratories, as well as descriptive, correlational, and experimental studies, which, taken as a whole, supports the effectiveness of SFBT [Solution Focused Brief Therapy].....SFBT has considerable empirical support and has sought to continuously ground itself in research evidence” (Trepper & Franklin, 2012, p. 411).

Solution-focused brief therapy is an evidence-based practice. The idea of evidence-based practice was originally conceptualized in the medical field in order to get improved client outcome (Sox & Woolf, 1993; Woolf & Atkins, 2001). SFBT is a new approach towards treatment and has gained popularity in a short span of time. Psychologists from different geographic locations have applied SFBT on varied psychological problems ranging from depression to family counseling. Solution focused brief therapy has been found to be widely taught and is being used in social work practice quite extensively (Franklin C. , 2015) .

2.1 Early Research at Brief Family Therapy Centre

Solution focused brief therapy developed in Milwaukee, Brief Family Therapy Center and mainly the work began by careful observation of the clients during counseling and noticing what and why of any progress being seen or reported. In other words, the work at the center was of exploratory and qualitative nature. The close observation of the therapy sessions made the observers conclude that instead of asking the clients what they want to change, they should be asked what they do not want to change. The application of this led to the details of what they do not want to change and also mentioned the positive changes happening in their life. With refinement, this result was incorporated as a step in first session (Adams, Piercy, & Jurich, 1991). Similarly, on the basis of the observations pre-session change question was also included in the

therapy (Weiner-Davis, de Shazer, & Gingerich, 1987). So, in this way, the keen observers, working in the development of the therapy minutely observed the session and the clients and by including or excluding what was found to be relevant or irrelevant respectively contributed in the development of what has come to be known as solution focused brief therapy.

2.2 Studies Related to The Treatment Outcomes

The results of a research study conducted by **Kiser** (Kiser, 1988; Kiser & Nunnally, 1990) reported 80.4 % success in average 4.6 sessions and after being contacted after 18 months, the rate increased to 86 %

From 1992 to 1993 a study of 275 BFTC clients was done by **De Jong & Hopwood** (1996) by measuring the outcomes in two ways; first was called intermediate outcome which was an index of the difference in client's scaling of his/her progress in the first and the last session. The second measure was called final outcome and included the data gathered by contacting the clients after seven to nine months and asking whether they met the goals or are they progressing towards the goals. The results indicate that significant and moderate progress was shown by 25 % and 49 % respectively and about 26 % showed not much progress. The final outcome criteria indicated that 45 % reported meeting their treatment goal, 32 % reported progress being made and 23 % reported no progress. The average sessions for the therapy were 2.9.

Lambert and Bergin (1994) after reviewing the different approaches concluded that the mean success rate of psychotherapy is 66 per cent with an average six sessions which is quite comparable to the success rate (25% + 49%) of SFBT in only three sessions.

Gingerich and Eisengart (2000; 2001) reviewed around 18 studies with control of solution-focused brief therapy. The criteria for the selection of the study to be incorporated in the review included an experimental design with proper assessment tools, randomised group or single case design, focus on a particular disorder, has a comparison group with alternate therapy or no therapy, the procedure adheres to some treatment manual, the outcome is measured and the group is large enough to detect the group difference with reliability. On the basis of these criteria, **Gingerich and**

Eisengart found seven studies which met 5-6 criteria, five studies which met 4 criteria and 6 studies which met 3 or less than 3 criteria. The results of the above 18 studies reflected significant improvement in 17 studies using solution focused brief therapy. The significant improvement was reported in 10 studies. Out of the 11 studies that compared the results of solution focused brief therapy with other standard treatment method, 7 reported that the profit from solution focused brief therapy to be same or better than the other treatment approach being used.

McKeel (2012) stated that the research studying the process of change dives deep into the therapy process including the therapy room to know the “what and why” of the intervention that influences the client or produces the reported change. This was the exact procedure that was used by the BFTC team in the process of development of solution focused brief therapy. **McKeel** (2012) after his thorough study concluded that the techniques of the solution-focused therapy accomplished the goals intended by the purpose of the therapeutic technique. Throwing some light on the experiences of the client taking solution focused brief therapy, **McKeel** (2012) reported that the clients were found to be more hopeful about their condition and expected positive results from the treatment. The clients also expressed satisfaction and appreciated the questions, techniques and the positive environment of the sessions. The clients were dissatisfied with this therapy when the therapist laid too much stress on the techniques and did not listen to the client’s concerns carefully.

Bavelas (2012) after reviewing the studies using solution focused brief therapy stated that the studies are proof of the collaborative and co-constructive nature of the therapeutic conversations. The publishing of the manual of solution focused brief therapy on the website (www.sfbta.org) is a step that has led to better understanding of the techniques and concepts of the therapy (Trepper, et al., 2012).

Kim (2006; 2008) found 63 empirical studies from the literature and did meta-analysis i.e. use statistical method to synthesise results from different studies by converting the results of those studies into a common measure (Kendall, Holmbeck, & Verduin, 2004). Kim decided to include all those studies into the analysis that used at least one of the four solution-focused procedures (i.e. miracle question, scaling, break,

compliments). On the basis of this criteria Kim was able to extract 22 from the original 63 studies. Dividing these 22 studies into three categories of internalising behaviour problems, externalising behaviour problem and relationship problems, Kim found that the effect was more for internalising problems as compared to the effect on externalising or relationship problems. The effect was not found to be significantly different than the effect of other psychotherapies. Another meta-analysis concluded that solution focused brief therapy is almost equivalent or bit better than other therapies, but it is definitely better than no treatment (Stams, Dekovic, Buist, & De Vries, 2006).

Gingerich et al (2012) after reviewing the research on SFBT stated that there are 46 well designed studies that compare the outcomes of SFBT with other established treatments and they show that it is equivalent to other evidence-based treatments producing results in comparatively less time and at less cost.

2.3 The Use Of SFBT On Client's with Different Problems/Disorders

The results from a study, comparing the mental health results of **substance abuse clients** who were randomly assigned to experimental group i.e. solution focused group therapy (SFGT) and Hazelden therapy and evaluated on Beck Depression Inventory and OQ (Outcome Questionnaire) Symptom Distress subscale, concludes that Solution focused group therapy lead to significant improvement on both the measures (Smock, et al., 2008).

One of the important studies reported by **Gingerich et al** (2012) is the one done by **Knekt** (2008; 2008b) as it is one of the few studies fulfilling the criteria of having a large number of subjects i.e. 326 subjects, used a clear diagnostic criteria for including subjects, the subjects were assigned randomly to control and experimental groups, the therapist were well trained, the SFBT manual was used and adhered to, and comparison between two evidence based therapies i.e. short-term psychodynamic therapy (STPP) and long-term psychodynamic therapy (LTPP) was made. The study compared mental health outcome of **depression and anxiety** patients receiving SFBT, STPP and LTPP. The average number of sessions of patients receiving SFBT was 10 over a period of 8 months, those receiving STPP were 19 sessions over a

period of 6 months and those receiving LTPP were 232 sessions over 31 months. The three year follow up of this study showed that all three therapies were almost equally effective outcome. The detailed analysis showed that the SFBT and STPP produced good results in 1 year and LTPP improvement was visible in 2 year which surpassed other therapy outcomes in third year. There was no statistically significant difference in the outcome or gains of the three therapies. This study supports the effectiveness of SFBT in less time in comparison to the time taken by the other therapies to reach the same level of improvement.

Trepper and Franklin (2012) reported the studies done by different researchers on different clients with different problems. Some of the studies reported are: **on schools** (Kelly, Kim, & Franklin, 2008), **on domestic violence and abuse** (Lee, Seebold, & Uken, 2003), **substance abuse** (Hendrick, Isabaert, & Dolan, 2012), **on management and coaching** (McKergow, 2012), **child protection services** (Wheeler & Hog, 2012), **medication adherence** (Panayotov, Strahilov, & Anichkina, 2012), and **on adolescents** (Corcoran, 2012).

Bond, Humphrey, Symes, and Green (2013) examined the effectiveness of SFBT with **families and kids**. They also reported weak methodology as major reason for ineffectiveness on one hand and the success of SFBT with internalizing externalizing problem in children on the other hand.

Franklin and colleagues (2001) studied the effect of SFBT on externalizing problems among elementary school students. The results indicated an ineffective treatment for hyperactivity index subscale was found to be 47.65 % which is considered ineffective. On the other hand, the subscale of Hyperactivity and Daydream Attention indicated mildly effective results. The Asocial and Conduct Problem reflected moderate effectiveness.

Yarborough (2004) studied the effect of solution focused brief therapy on completion of assignment and the rate of accuracy with which the work was done by six elementary school students. The results were found to be quite opposite for assignment completion and assignment accuracy. SFBT proved to be effective for assignment completion with completion rate of 93.8% but ineffective for assignment accuracy with the accuracy rate of 0%.

Franklin et al (1997) found SFBT to be almost 100% accurate with the adolescents. He measured the externalizing behavior problems in three adolescents using self-anchored scales and made them identify the behavior that they wanted to change during the sessions. The results reflected 100% success rate proving the high effectiveness of SFBT.

Conoley et al (2003) studied the effectiveness of SFBT on the frequency of problems in three children who were diagnosed with oppositional aggressive behavior and on the basis of daily report of problem frequency by the parents found it to be yielding 0% results indicating ineffectiveness of SFBT with such problems.

Jakes and Rhodes (2003) studied the effectiveness of SFBT on five adults having delusions and the results indicated minor improvement for conviction and negligible to zero percent for preoccupation and distress respectfully proving the therapy to be ineffective.

Franklin et al (2001) studied seven students with internalizing behaviors using the subscale Anxious-Passive and Emotional Indulgence of Connors Teacher Rating Scale. The results of Anxious-Passive subscale indicated the therapy to be ineffective and the Emotional Indulgence subscale indicated the SFBT to be mildly effective.

Nelson and Kelley (2001) examined the marital satisfaction and found SFBT to be mildly effective on Revised Dyadic Adjustment Scale (RDAS) but ineffective on Kansas Marital Satisfaction Scale (KMSS).

Naude (1999) also studied marital problems and found SFBT to be moderately effective for Relationship Thermometer Ratings but ineffective for goal attainment.

Polk (1996) studied the effect of SFBT on alcohol drinking behavior and attendance rates at work for adults in an employee assistance program and found 100 % abstinence for daytime drinking and increase in attendance at work thus reflecting high effectiveness for alcohol abstinence and mild effectiveness for attendance at work.

Estrada and Beycbach (2007) explored the capableness of SFBT on deaf and depressed individuals. They reported that depression symptoms reduced considerable in 4 to 8 sessions, thereby reflecting moderate success.

In an effort to compare the effectiveness of SFBT and alternate therapies, **Schmit, Schimt and Lenz** (2016) analyzed 12 studies using SFBT and alternate

therapies and concluded that clients receiving SFBT reported almost 24 % less symptoms of one standard deviation than those who received other therapeutic treatments. They also concluded that role of mediating variables played an important role. To this end, they found that heterogeneity of sample was responsible for approximately 61 % of total variability. On the other hand, interest played negligible role. The further analyses of effect of age group revealed no significant differences of effect between youth, adolescents and adults.

From the evaluation of 26 studies, **Schmit, Schmit and Lenz** (2016) found that the decrease in internalizing symptoms in youths and adults was small in comparison to other treatment approach or no treatment. **Bond et al.** (2013) also found that SFBT had partial effect on internalizing disorders among children. **Corcoran and Pillai** (2009) reviewed effectiveness of SFBT but did not report conclusive results. It is suggested in some studies that counselor and mental health professionals should consider severity of symptoms of internalizing disorders like depression and anxiety (Erford, et al., 2011), (Erford, Kress, Giguere, Cieri, & Erford, 2015) for implementing an effective treatment approach based on research offering practical meaningfulness.

The study of the effectiveness of SFBT shows that for depression the SFBT leads to almost 24% improvement in 6-9 sessions which quite progressive when compared to other approaches. In other words, SFBT leads to significant transformations in short time. The effectiveness of SFBT has been recorded for internalizing disorders (Schmit, Schmit, & Lenz, 2016); for intellectual disabilities (Roeden, Maaskant, & Curfs, 2014); group therapy with grownups on problem control (Quick & Gizzo, 2007); with group therapy on students with marked up self-regulation (Fitch, Marshall, & McCarthy, 2012). A depth analysis of effectiveness of SFBT with different age group revealed that it was 5 times better on adults than on youth and adolescents. Further SFBT produced results two times better results on international domicile clients than on US domicile clients. **Kim et al.**, (2015) reported the effectiveness of SFBT in reducing internalizing disorders in Chinese clients.

Different studies have studied the outcome of applying Solution focused brief therapy on childhood and teenage problems. **Kim and Franklin** (2009) did a systematic review of the available studies and included seven studies in that. Of the seven studies only one was experimental and other six were quasi experimental. Other positive aspects of the studies were that there was more than one investigator, the treatment manual was used, standardized measure were used, fidelity evaluation was done and the studies were done in real life situations. The research results showed that SFBT had better engagement adherence and few dropouts as compared to Cognitive behavioral therapy given to 86 students in the age range of 5-17 years with behavioral problems like aggressiveness, conduct problems, and impulsivity. The post-test scores did not show any significant differences as both the groups received the therapy. The results reflect that though there was improvement in all the participants but the group receiving solution focused brief therapy showed better adherence to treatment engagements and there were few dropouts (Corcoran, 2006)

Another study reviewed by **Kim and Franklin** (2009) found the effect of SFBT on internalizing problems among school children. The study was designed to see the effect of group SFBT on the self-esteem of children of prisoners and included 10 elementary school children, 5 in experimental group and 5 in control group. The different techniques of SFBT like miracle question, scaling question, exploring the exceptions etc. were incorporated. The results reflected a statistically significant gain in the self-esteem of group with SFBT treatment and there was negligible advancement in control group (Springer, Lynch, & Rubin, 2000).

Another research designed to see the effectiveness of SFBT on behavioral problems and internalizing outcomes among 67 students found that the there was significant decrease or improvement in both internalizing and externalizing scores on the measure used i.e. Teachers Report Form. The results reported large effect for the internalizing problems and medium effect on externalizing problems. In contrast the score of Youth Self-Report did not show much difference in the experimental group that was given SFBT and the control group for the internalizing problems. On the other hand, the Youth Self-Report reflected a considerable drop in the externalizing problem scores (Franklin, Moore, & Hopson, 2008).

The research to study the effect of solution-focused brief therapy on academic performance was also carried out. One study was done by **Newsome** (2004) on middle school students with academic and attendance problems. There were in total 52 students, 26 in experimental group which was given Solution focused brief therapy and 26 in control group for comparison who did not receive any treatment. The control group was given SFBT once in week for 8 weeks where the techniques like scaling, miracle question, goals and study work were used. The results indicated a medium effect on grades of experimental group and no statistical variation for attendance between the SFBT and comparison group.

Franklin & Gerlach (2007) did a study on two groups of high school children to study the effect of SFBT on credits, attendance and graduation rate using a quasi-experimental design. The aim was to evaluate the effectiveness of SFBT in dropout prevention. The experimental group which was given SFBT had 46 students and the comparison group had 39 students. Both the groups were matched on the at-risk characteristics. The score of the repeated measure ANOVA showed that there was a change in credits attempted by both the groups. The independent sample t-test showed that the experimental group earned significant higher credits than the control group. On the other hand, the comparison group had more improvement in attending classes than the experimental group. **Franklin and Gerlach** (2007) added that the experimental and control group should not be compared for attendance as the experimental group was on self-paced curriculum where they could stop attending classes once the curriculum was completed thus making it an inaccurate measure for determining the effect of intervention.

To evaluate the graduation rate, **Franklin & Gerlach** (2007) followed up all the students of experimental and control groups. They found that 90% graduated from the control group while only 81% graduated from the experimental group and the remaining students were still enrolled in the different schools.

Froeschle, Smith & Ricard (2007) designed a study using randomized experiment design to examine the effectiveness of SFBT on self-esteem, academic problems and substance abuse. The subjects were adolescent females and the techniques that were used included SFBT group sessions, mentoring and action learning with an aim to reduce the substance use and behavioral issues. The results supported SFBT as

statistically significant difference were reported between the two groups on drug use, attitude towards drugs, knowledge of symptoms of drug abuse and behavior scores as reported by parents and teachers.

The defining of small, concrete goals in Solution-focused brief therapy works well in school situations as they have finite time and basics (Murphy, 1996)

Harris and Franklin (2002; 2008; 2009) designed a Taking Charge (TC) intervention to help adolescent mothers. The aim was to reduce the absenteeism and improve grades among the adolescent mothers in district high schools. Three studies were designed; one was randomized clinical trial and the other two were quasi experimental studies. Results found a significant high-grade point average for experimental group in all three studies. Other indicators of improvement were social problem solving and active coping. These results were found to be true at even 6 weeks follow up.

Solution focused brief therapy has also been used for alcohol treatment. **Miller, Wilbourne and Hettema** (2003) reviewed 381 outcome studies of alcohol treatment and found the brief therapy models to be quite effective for alcohol problems. It was found that common factors like empathy, hope and self-efficacy exerted a strong influence of the effect. The principles of SFBT were found to be more influential than the technique. The inclusion of family members and the partners in alcohol treatment and using the family therapy approach of SFBT that includes reducing pessimistic interaction, overcoming the obstacles to change, reframing the thought process and improving behavioral competence had significant impact in reducing the alcohol problems (Isebaert L. c., 2004; 2007).

Solution focused brief therapy has also been used on the **adolescents in foster care**.

Van Dyk (2004) conducted a study to see the effect of SFBT on recidivism rate of adolescent offenders in foster care. The results indicated that adolescents' offenses reduced significantly with lesser return to foster care. This study lacked standardized measures, and absence of comparison group. **Koob and Love** (2010) reported significant decrease in disruptions in foster care adolescents' who were given residential treatment using SFBT.

The use of SFBT in mental health care settings reported 77% and 54% improvement in the client's satisfaction or improvement in the problem situation and helped them reach their goals (Burr, 1993; Lee M. Y., 1997).

The collaborative clinical environment and stress on the client's strength rather than on the expertise of therapist decreases the resistance of adolescents' and motivates them to continue therapy (Bertolino, 2003; Corcoran & Stephenson, 2000; Lethem, 2002)

A study with 112 subjects in treatment group and 91 in control group from foster care homes, mental health care Centre and rehabilitation hospital was conducted to see the effect of SFBT on the perception of problem, client's behavior and general adjustment. The results concluded that there were significant improvements in perception of problems and psychological adjustments of the adolescents from all the groups in an average of three sessions. These results lead to the belief that SFBT can meet the requirements of adolescents and can be the first choice of intervention for them (Pakrosnis & Cepukiene, 2012).

Five well controlled studies using SFBT were reported which reflect significant improvement in depression among college students measured on Beck Depression Inventory (Sundstrom, 1993); significant improvement of parenting skills measured on Parenting Skills Inventory (Zimmerman, Jacobsen, MacIntyre, & Watson, 1996); significant between group differences of the orthopedic rehabilitation patients on Family Crisis Oriented Personal Evaluation Scales and the Psychological Adjustment to Illness Scale Revised (Cockburn, Thomas, & Cockburn, 1997); decrease in the recidivism rates among both the adult Swedish prison population and institutionalized adolescent offenders (Lindforss & Magnusson, 1997; Seagram, 1997).

Therefore, SFBT has been found to be a good therapy for variable problems. SFBT can be called a therapy model which by building the meaning along with the client, bringing forth the strengths of the client, by having a good bond with the client sets attainable goals, arouses hope in client and thus, helps the client to reach the solution (Franklin, Zhang, Froerer, & Johnson, 2017).

2.4 What Works in SFBT?

Solution focused brief therapy (SFBT) is one of the evidence-based therapies which have developed at every step with feedback from practice and modifying with every insight. The search for solution focused therapy began with the question “What works in therapy” and the Shazer’s team noticed every detail of the session, recording videos, viewing again and again till the reason for change could be identified and incorporating every idea into what developed into solution focused brief therapy. The research on change process in solution focused brief therapy included a study of investigating techniques, optimism of the client and exploring the client-therapist relationship as these were vital reasons for the success of psychotherapy (Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 1992; Norcross, 2002). Solution focused brief therapy has been found to be quite effective. The main reason behind its success is that the client and counselor together work on the client’s frame of reference, his/her experiences and their preferences (Berg, 1997).

2.4.1 Pretreatment improvement.

The first session questions of SFBT include a question on pretreatment improvement. It requires the details of change the client has experienced with the hope of going for treatment or anything the client has tried before coming for the session (de Shazer, 1985; 1988). This helps the therapist to focus on client’s strengths and his/her resource and also helps in knowing the exceptions to the problem situation. SFBT requires the therapist to know anything that helps or improves the client’s situation so that the therapist can help the client increase his/her optimism and motivation levels. So, in this way pretreatment improvement is like a guide for building solutions by helping continue doing that helps in bringing the goal closer (McKeel J. , 2012). Research has found pretreatment improvement in 30% cases (Allgood, Parham, Salts, & Smith, 1995); 15percent improvement in problems before treatment (Howard, Kopta, Krause, & Orlinsky, 1986); the clients reporting pretreatment improvement have been found to complete the therapy successfully (Beybach, Morejon, Palenzuela, & Rodriguez-Arias, 1996; Johnson, Nelson, & Allgood, 1998); clients report pretreatment change when the therapist asks about it (Kindsvatter, 2006; McKeel & Weiner- Davis, 2009).

2.4.2 Presupposition questions.

Solution focused brief therapy is an evidence-based approach in which presupposition questions play a vital role. The presupposition questions are questions which are positively constructed so as to communicate positive belief or raise hope in the client regarding their future expectation, present footing or their ability to achieve treatment goals (McKeel J. , 2012). So, a solution focused therapist should ask “What has helped in dealing with this situation in the past?” instead of “Have you tried anything that worked?” The main difference in these two questions is that the first question reflects that the client has definitely been successful in dealing with the situation (O'Hanlon & Weiner-Davis, 1989). In this way the question is constructed in such a manner that it helps in promoting hope in the client, helps them in identifying their strength, capability, success and future possibilities (MacMartin, 2008; O'Hanlon & Weiner-Davis, 1989). The research done on presupposition questions reflects that when positively constructed questions are asked from the client regarding pre-treatment change, 66.67% clients reported improvements with details of the improvement (Weiner-Davis, de Shazer, & Gingerich, 1987); 60% clients reported pretreatment improvement in the replication of same study (Lawson, 1994; McKeel & Weiner- Davis, 2009); 53% reported improvement in the questionnaires on presuppositional questions (Johnson, Nelson, & Allgood, 1998).

In another study, the clients reported that the presuppositional questions make them feel as if the therapist is not listening to them or understanding their problem, so it is advised that the therapist should first acknowledge the client’s problem and then ask pretreatment questions (MacMartin, 2008).

2.4.3 Miracle question.

Miracle question is like a cornerstone of solution focused brief therapy and is usually asked in the first session. The example of miracle question is:

“Now, I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem which brought you here is solved. However, because you are sleeping, you don’t know the miracle has happened. So, when you wake up tomorrow morning,

what will be different that will tell you a miracle has happened and the problem which brought you here is solved?" (De Jong & Berg, *Interviewing for solutions.*, 1998, pp. 77-78).

The miracle question is like the heart of solution focused therapy and is rated as one of the distinguishing techniques it offers (Skidmore, 1993). The client's answer to the direct the progress of the therapy as it helps in specifying the desired goals and visualize the future life (de Shazer, 2002). The SFBT miracle question is introduced to achieve the different goals that include developing and treatment, promote hope and prepares the client for exceptions (de Shazer, et al., 2007). Research has supported the attainment of these goals by SFBT: the miracle question has been found to elicit response about variety of issue which led to concrete, relational, and emotional/ affective progress and felt more confident after responding to the miracle question (Dine, 1995; Shilts, Rambo, & Hernandez, 1997); clarifies/ develops goals and identifies ways to accomplish those goals (Isherwood & Regan, 2005; Shilts, Flippino, & Nau, 1994).

As the miracle question has been found to be quite an effective technique so, efforts have been made to make it more successful. It has been found that:

- The therapist should make the rapport with the client ahead of putting up the miracle question.
- The exceptions question should be asked before moving to miracle question.
- It is important to empathize and understand the client in the discussion preceding or during the miracle question.
- The therapist should not make any suggestions while the client is answering the miracle question.

An adherence to these suggestions has been found to be more effective in making the clients receptive, cooperative and elicited detailed answer to the miracle question (Nau D. S., 1997; Nau & Shilts, 2000)

Though, lot of research has supported the benefits of miracle question yet some studies have reported that depressed clients found it difficult to answer the miracle

question (Estrada & Beyebach, 2007); terminally ill clients focused on medical recovery in miracle rather than about achievable improvements (Bowles, Mackintosh, & Torn, 2001); mothers of intellectually disable children found the miracle question quite confusing or irrelevant even after two weeks after the first session but found envisioning an hypothetical future in first session quite useful (Lloyd & Dallos, 2008). These studies indicate a need to cautiously construct the miracle question and rephrase it as per the needs of the clients especially in clinical situations (McKeel J. , 2012).

An in-depth study of the de Shazer's use of miracle questions shows that miracle question was not used as a single question but as a part of multi-question process where the therapists tries to understand the clients' answer, and then frames more questions to elicit further details about the change visualized, differences the miracle would make and any past situation with anything similar to the occurrence of miracle (de Shazer, 2002).

From the above studies that cited showing the limitations of miracle question, the details of whether the miracle question was used as a single questions or multi-question approach was used, are not available, so nothing conclusive about the limitations of the miracle question can be said.

2.4.4 First session task.

First session talk or formula first-session task (FFST) is the task or work given to the client by the therapist towards the end of the first session. The task includes an advice to observe all the desirable things happening in the client's family life, marriage or any other aspect important to him/her and he/ she wants it to go on and describe the same to the therapist in the next session (de Shazer, 1985). The main objective behind the use of FFST is to inculcate hope of improvement, to increase the chances of noticing these improvements or exceptions and motivate the client to make effort to achieve the desired goals.

The FFST descriptions are the main aspect of second session and is like a follow up of the reported hope, exceptions to problem and any improvement noticed. All this information paves the way to help the client develop possible solutions and continue

these positive changes. A study reported from BFTC found that 89% of 56 clients reported that between the first and second session something positive and worthwhile happened, 82% said that they noticed something new and desirable that they want to continue happening and 57% reported their situation to be better (de Shazer, 1985).

Another study compared the clients given solution focused FFST homework and clients given problem focused homework from any other problem focused first session therapy. It was found that FFST group clients had more chances of completing the homework than those in the problem focused first session group. Further, the FFST clients were clearer about their goals and were more likely to report improvements than the other group. However, when compared on the amount of hope and chances of accomplishing the treatment goals, no significant differences could be seen in both the groups (Adams, Piercy, & Jurich, 1991); the clients from FFST group were more optimistic about the success of therapy than the problem focused therapy group and rated the first session to be more productive and positive than the other group (Jordan & Quinn, 1994); a client narrated his experience of first session of SFBT and said “ your homework in the first session, noticing strengths, I was surprised to discover how well I was really handling things” (Mireas & Inch, 2009).

2.4.5 What’s better?

After the first session, from second session onwards the SFBT therapist asks the client, “What is better since our last visit?” (de Shazer, 1994). A study by SFBT trained therapist from BFTC reported that 129 clients from this question was asked, 76% answered it in positive i.e. they reported that every session did bring in some improvements (Reuterlov, Lofgren, Nordsbrom, Ternstrom, & Miller, 2000).

2.4.6 Scaling questions.

In solution focused brief therapy the scaling question by the therapist is asking the client to rank the problems, desired goals and other problems on a scale of 1 to 10 with 1 indicating the worst situation and 10 indicating the desired miracle. It helps in indicating the progress from one session to another and helps in identifying the tools leading to these improvements with further boosting the confidence of success. After getting the rating, the therapist explores the reasons for the reported changes and how

the frequency of such behavior can be increased to move up on the scale. This helps in clarifying the steps to achieve the treatment goals. The therapist enquires about the change that will take the client one step up on the scale. For example, if the client says he/she is on 3, then the therapist will ask what will be different when the client is at 4. He will identify one or two things that can be done till the next session to improve the rating on the scale (de Shazer, 1994). Scaling is one of the most frequently used techniques by the SFBT therapist (Skidmore, 1993).

It has been found that in cases where the clients criticized the miracle question, described the scaling question to be useful (Estrada & Beyebach, 2007; Lloyd & Dallos, 2008). The researchers reported that the clients were able to understand the scaling questions easily and these questions helped them know the specific steps that can be taken to accomplish the desired treatment goals (Estrada & Beyebach, 2007); the client found the scaling question to be the most useful aspect of SFBT as it helped gaining insight that though he/she was at 1, there were times when he/she had been on 4 or 5 i.e. helped in remembering happy or positive times which gave hope of better future (Lloyd & Dallos, 2008).

2.4.7 Solution talk.

The most characteristic feature of solution-focused brief therapy (SFBT) is the conversation between therapist and client with focus on change and solutions (McKeel J. , 2012). The SFBT therapist indulges in solution talk, i.e. instead of giving advice, educating, directing or providing suggestions, the therapist with the help of summarizing and paraphrasing, asks questions that help the client discover, improve and achieve desired treatment goals (de Shazer, 1991; 1994).

The therapists' questions help in the exploration of pretreatment change, exceptions to the problematic situation, previous success, the resources and competencies of the client that can help in achieve the desired goals and make progress. During the session, the therapist usually listens to the client carefully and absorbing the answers ask further question that connect, amplify and helps in building responses that help in making the progress (de Shazer, et al., 2007). From the examination, of the BFTC team's transcripts of the first session SFBT conducted at BFTC, **Gingerich et al**

(1988) it was noticed that client's responses were quite different to solution talk as compared to the problem talk. The questions on successes and situations without/ lesser problems; when the focus is on goals, the clients talk about positive change, about exceptions to the problem, talk about innovative ways of looking at the problems, and talk about progress or solutions they desire to attain the goals. The clients talked about solutions, change or progress, when they were asked by the therapist. This study also reflected that during the earlier research at BFTC on SFBT, the first session mainly focused on the problem talk and the later sessions consisted of change talk or solution talk. The experiments by the BFTC team slowly and slowly made them change the first session from "problem talk to solution talk."

Conversational analysis of the four videotaped first sessions of Steve de Shazer and Insoo Kim Berg (SFBT therapist) and the comparison with Carl Roger's and Raskin's client centered therapy, it was found that Shazer and Berg asked much more questions than the therapists in other two client-centered therapists. On rating the therapists' questions or utterances as positive, neutral or negative, the researchers found that SFBT therapists' positive utterances were almost four times more than the utterances of client-centered therapists (Tomori & Bavelas, 2007).

Studies have also shown that with increase in solution talk by SFBT therapist, the clients' solution talk also increases (Bonsi, 2005; Speicher-Bocija, 1999). Studies have also reported that the solution talk by the client in the first session is related to his/her continuing therapy. More the solution talk by the clients' in the first session, more are their chances of completing the therapy (Shields, Sprenkle, & Constantine, 1991); the positive association has been found between the identification of clients' strengths by the therapist and positive outcome of the treatment (Corcoran & Ivery, 2004)

2.4.8 Clients' experiences of SFBT.

Lot of research is being conducted on the effectiveness of SFBT. The review of the Clients' report of the therapy shows that with the use of SFBT techniques, there is an increase in the clients' hope and expectations about the success of therapy (Corcoran & Ivery, 2004; Dine, 1995; Jordan & Quinn, 1994; 1997; Shilts, Rambo, &

Hernandez, 1997); a comparison of SFBT and problem focused therapy clients after three sessions also shows that the SFBT therapy clients' reported higher expectations of achieving the desired goals (Bozeman, 1999); clients from SFBT group therapy attributed the hope to SFBT principles and one client explained that the solution to his problems "might be an accumulation of small everyday victories that are known, doable, and within my grasp. Just keep doing what works, no matter how small" (Quick & Gizzo, 2007, pp. 65-84).

An interview of the clients who had completed SFBT to find out their report of what was most helpful in the therapy, fifty three said that they found the questions, homework, techniques as the most influential part of therapy, twelve said that the encouragement and the feedback given by the therapist helped, 25% found the talking about the problems as influential, the analysis of the videotapes of the sessions reflected that during the first session 15.5% (7.4 minutes) of time was spent on discussing the problem and this reduced to 1.4 minutes in subsequent sessions and the clients found the solution talk to be useful (Simon & Nelson, 2004); clients have reported having noticed and liked the positive environment of the solution focused brief therapy environment with focus on the strengths (Mireas & Inch, 2009; Monro, 1998); clients' found the therapy to be empowering and collaborative (Batzel, 1997; Lloyd & Dallos, 2008); clients in some studies reported having experienced support, validation and positive focus in SFBT which they found to be quite empowering (Lee M. Y., 1997; Shilts, Flippino, & Nau, 1994); in another interview the SFBT clients appreciated the acknowledgement of their skills and achievements by their therapists (Lloyd & Dallos, 2008).

A study conducted to examine the effect of solution-focused brief career counseling on reducing the indecision among the university students found that solution focused brief therapy was quite effective in minimizing the career related indecisiveness of the client (Akyol & Bacanli, 2019).

Some other reviews of comparison of the reports of clients' from SFBT and problem focused therapy found no differences in therapists' support, input, assistance and the

opportunity of problem discussion (Speicher-Bocija, 1999); no differences of client-therapist alliance (Jordan & Quinn, 1994).

The success of SFBT has also been found to be linked to specific therapist-client interaction. Sensitivity of the therapist along with appropriate reactions, attention to timings, ‘fit’ of the action and ability to wait for the client’s response have been found to be influential for the clients (Kowalik, Schiepek, Roberts, & Elbert, 1997); the success of the therapy is also found to be linked with the relatedness of the therapists’ question to the clients’ last response (Beyebach & Carranza, 1997); if the therapist practices active listening, paraphrases and makes statement like “I understand” or “I see”, the client feels encouraged and works toward their goals (Beybach, Morejon, Palenzuela, & Rodriguez-Arias, 1996).

Some studies have also explored the reasons of dropout from SFBT. It was found that the interruption and talking over of the client by the therapist made them quit the therapy (Beyebach & Carranza, 1997); if the clients experience the therapist to be more dominating or controlling then also they drop (Beybach, Morejon, Palenzuela, & Rodriguez-Arias, 1996).

It has also been observed that though the solution focused approach encourages asking questions from the client, yet when the suggestions or advice is offered by the therapist in SFBT family therapy, clients highly value it (Lloyd & Dallos, 2008)

An experiment was done in a mental health center, where for 6 months SFBT was used primarily and the therapist did not ask about the client’s problems. This made the clients critical and they reported feeling unheard and not understood. They reported feeling as if the team has their own agenda. When the therapist started talking about the problems, the clients’ criticism declined (Macdonald, Research in solution-focused brief therapy., 2003).

2.5 Gaps in Research

Solution focused brief therapy is a new therapy which has generated a lot of interest and research. Though lot of research has been done, but the reported studies have some limitations. Some of the limitations are:

- **Small number of studies:** The amount of research literature on SFBT is not very exhaustive and more research needs to be done as multiple studies enhance the confidence in the technique.
- **Lack of ample research for strong evidence:** SFBT technique has not been established as a strong tool for any specific problem or problems due to lack of sufficient research.
- **Lack of studies meeting standards:** The review of literature lacks studies meeting the criteria for research quality. **Bond et al.** (2013) found that out of 38 studies, only 5 studies met the criteria for research quality.

As SFBT is a relatively new approach, there is a lot of research gap. Though some studies report the effectiveness of SFBT on a variety of problems and different individuals of varied age and geographic areas, still the data available is not enough to reach a conclusion. The research carried out on SFBT makes us reach the conclusion that though SFBT produces modest differences in different problems, yet it is very good therapy in terms of modest effect and time taken. So, the solution focused therapy should be studied by carefully designed research on specific age-groups or specific disorder so that conclusive evidence is made available.

2.6 Logic/Need of The Study

The review of the existing research on the SFBT presents the following information:

1. SFBT has been the focus of interest for different researchers but not much work has been done to study the effectiveness of SFBT on specific problems of college students. As youth is the future of the nation, so research to help them deal with their problems is required.
2. In India, SFBT is at the infantile stage. Though some work is being done at NIMHANS (National Institute of Mental Health and Neurological Sciences), Bangalore, not much work is going on to study the effectiveness of SFBT on depression and anxiety among college students. Keeping in view the

regional disparities, more research with different age groups from different regions is required.

3. The rising number of psychological problems and the shortage of psychology experts reflect on the need for short-term therapy. So, research to establish the brief therapy like solution focused brief therapy is need of the hour.

4. A search on Shodhganga, the online reservoir of Indian thesis shows no results on SFBT. This confirms the novelty of the topic.

5. Search for related research also ended up with negligible studies on the effectiveness of SFBT on depression and anxiety among college students. So, research on the problems of college students is needed.

Hence, from the above facts, it is evident that this is a novel topic and if the results of this research are promising then this will prove to be a major milestone for society.

2.7 Significance of The Study

According to the World Health Organization, depression and anxiety are among the most prevalent problems in India. The same report reports that there are very few psychologists available. So, short treatment with immediate relief is the need of the hour. This study will study the effectiveness of SFBT which yields results in 3-6 sessions on anxiety and depression in college students. The college students are the future of the nation and constitute the most energetic age group. So, an effective treatment for their problems is of utmost importance.

CHAPTER 3

METHODOLOGY

3.1 Statement of The Problem

A Study of the effectiveness of Solution-Focused Brief Therapy on Anxiety and Depression in College Students

3.2 Objectives/Scope of The Study

The present study aims to study the effectiveness of SFBT on anxiety and depression in college students. SFBT is time effective and economical therapy with good results in varied situations. The objectives of the present study can be enumerated as follows:

1. To study the impact of Solution-focused brief therapy on the level of anxiety.
2. To study the impact of Solution-focused brief therapy on level of depression.
3. To find out whether anxiety/depression of college students differs by the demographic variables gender and socio-economic status (SES).

3.3 Hypotheses

Hypothesis 1: Solution-focused brief therapy will have a positive impact on reducing the level of anxiety in college students.

Hypothesis 2: Solution-focused brief therapy will have a positive impact on reducing the level of depression in college students.

Hypothesis 3: Demographic variables will make a significant difference in anxiety, and depression in college students.

3.4 Variables And Their Operational Definitions

The definitions of the independent and dependent variables of the present study are given below:

3.4.1 Independent variables definition.

3.4.1.1. *Solution Focused Brief Therapy (SFBT).*

Solution focused brief therapy popularly known as SFBT is an evidence-based therapy. It was developed by Steve de Shazer and Insoo Kim Berg in 1980s at the Brief Therapy Centre in Milwaukee, Wisconsin. It assumes that the client has the means to deal with the problem. The counsellor helps the client in recognizing and maximizing the utilization of those resources. It proceeds by diverting the client's attention from problems to solutions. The client himself/herself chooses the goals for the therapy and uses the resources to make the change to reach the desired goals. This therapy does not require detailed history of problem. It focuses on the solutions and the ways to attain the solutions. The questions on exceptions, miracle and scaling are the heart of this therapy and feedback acts as a motivation to change for the desired end. So, in this way as the name suggests, this therapy works by focusing on the solutions, effectively produces changes in 3-5 sessions and almost 25 per cent improvement in the first session (Macdonald, 2007), thus making it a brief therapy.

The Indian system is highly conducive for SFBT. It can also be said that SFBT is the need of the hour in the Indian system. The reason behind the relevance of SFBT in Indian scenario is that although the high pace of development is leading to a rise in mental health concerns and contrarily there is scarcity of time and finances require a quick and solution focused approach. The SFBT is also relevant from another perspective. India which has a population of 1.25 billion out of which almost 20% people are below poverty without any health insurance for mental illness. Apart from this, less than 1 clinical psychologist is available per 1 million populations (Rehabilitation Council of India, 2015). All these reasons point to the growing need of a time and resources of effective treatment. The brief therapeutic treatment models are very vital for present Indian clinical scenario as they are quite economical and less time-consuming giving results in short span of time.

3.4.2 Dependent variables.

3.4.2.1 Anxiety.

The word anxiety is derived from Latin root “anxietas” i.e. to stifle, agitate, feel inconvenience and throttle. Anxiety is implied to a behavior in which feelings and reactions to threat dominate. Anxiety is a feeling of uneasiness or nervousness. In other words, constant state of worry can be called anxiety. American Psychological Association defines “anxiety as an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure. People with anxiety disorder have recurring thoughts and have a tendency to avoid certain situations” (Anxiety, 2017). It can be said that anxiety becomes neurotic anxiety when the feelings of fear get stretched to all the life situations without any control.

The Diagnostic and Statistical Manual 5 (DSM-5), a classification manual of mental disorders by American Psychiatric Association, 2013 lays down the following criteria to diagnose generalized anxiety disorder:

1. The behavior includes excessive anxiety or worrying about day to day activities or tasks. This behavior pattern is present for at least 6 months and can be called excessive.
2. The constant worry is difficult or beyond the individual’s control. Though the worry may change from one topic to other, but it is almost always present.
3. The worrying behavior is paired with minimum three of the following indications- uneasiness, weariness, impaired concentration, peevishness, increase in complains of aches or changes or difficulty in sleeping. (American Psychiatric Association, 2013).

The constant fear or anxiety makes it difficult to carry on day to day activities smoothly and may even affect personal or professional relationships. Anxiety includes negative thoughts with anticipated danger or threat as the centre.

3.4.2.2 Depression.

According to World Health Organization (WHO) “Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration” (Anon, 2017). The Oxford English Dictionary defines depression as “a mental condition characterized by feelings of severe despondency and dejection, typically also with feelings of inadequacy and guilt, often accompanied by a lack of energy and disturbance of appetite and sleep.” (2017). Depression is becoming so common that WHO has addressed it as a one of the most prevalent health problems in India which is leading to disability on one hand and socio-economic losses on the other hand (WHO, 2017). WHO slogan for 2017 World Health Day is “Depression-Let’s Talk” signifying the severity of the problem. Though on the surface depression is related to feelings of sadness, reduced interest in daily activities, and loss of energy or fatigue, at the deeper level it is also related to suicide.

3.5 Description of Subjects

The study is a quasi-experimental research. Purposive and convenient sampling was done to select subjects as per the criterion. The details of the subjects are described:

3.5.1 Gender.

Equal number of males and females were selected and were randomly assigned to experimental and control groups. The Table 3.1 shows the details of the groups on the basis of Gender. It can be seen that 30 males and 30 females were selected with 50 percent composition of each.

Table 3.1
Showing the details of the Groups based on Gender

Gender			
Variable	Sub Variable	Frequency	Percent
Gender	Male	30	50.0
	Female	30	50.0
	Total	60	100.0

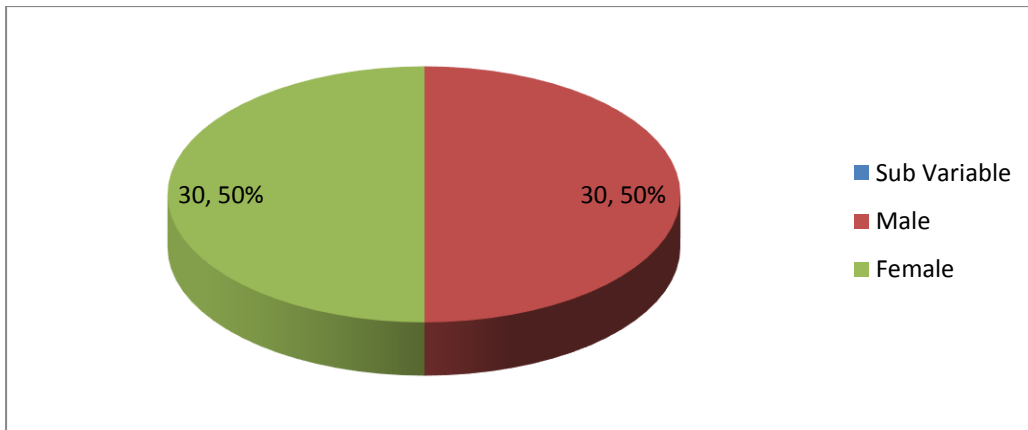


Figure 3.1 Showing the Group details based on Gender

Figure 3.1 shows the proportion of male and female subjects in the study as a pie chart. The pie chart also reflects an equal number of males and females in the study. So, it can be inferred that the present research has equal proportion of male and female subjects. This will help in keeping the gender variable constant in both the groups i.e. experimental and control group.

3.5.2 Number of participants.

A total of 60 subjects meeting the criterion of inclusion were selected. They were randomly assigned to the experimental and control group.

Table 3.2

Showing Group details based on Number of participants

Group			
Variable	Sub Variable	Frequency	Percent
Group	Experimental	30	50.0
	Control	30	50.0
	Total	60	100.0

Table 3.2 Shows the group details on the basis of the number of participants. The table reflects that the control group and the experimental group had 30 subjects each. Both the groups had the same percentage of subjects. A visual inspection of Figure 3.2 showing group details based on number of participants confirm the equality of both the groups.

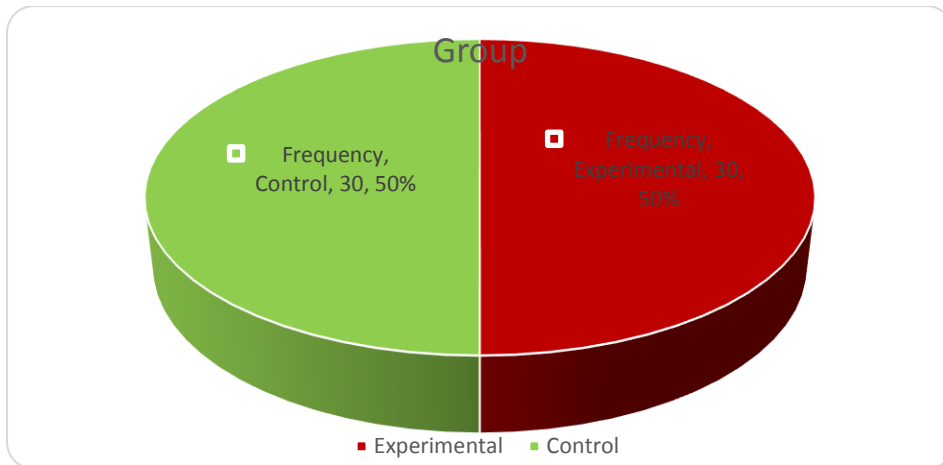


Figure 3.2 Showing Group details based on Number of participants

3.5.2.1 Experimental group details.

The experimental group was composed of 15 males and 15 females. It is shown in the table 3.3.

Table 3.3

Showing Experimental group details based on Gender

Experimental Group			
Variable	Sub Variable	Frequency	Percent
Gender	Male	15	50.0
	Female	15	50.0
	Total	30	100.0

Table 3.3 shows the experimental group details based on gender. The experimental group had 15 males and 15 females. Figure 3.3 shows the experimental group details based on gender. The equal halves of the right side of the pie chart reflect that the experimental group had 50 per cent males and 50 per cent females. So, the experimental group had equal representation of both genders.

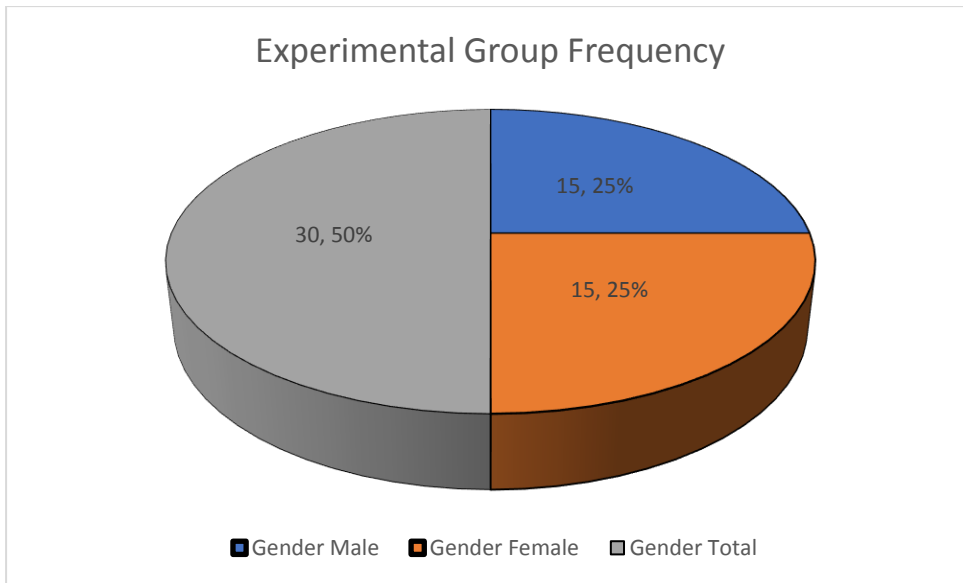


Figure 3.3 Showing Experimental group details based on Gender

3.5.2.2 Control group details.

The control group was similar to the experimental group on the basis of gender. It had equal representation of males and females.

Table 3.4

Showing Control Group details based on Gender

Control Group			
Variable	Sub Variable	Frequency	Percent
Gender	Male	15	50.0
	Female	15	50.0
	Total	30	100.0

Table 3.4 shows the control group details based on gender. The table shows that the control group had 15 male subjects and 15 female subjects. Figure 3.4 shows the control group details based on gender as a pie chart. The equal halves of the pie represent the equal percentage of male and female subjects in the control group.

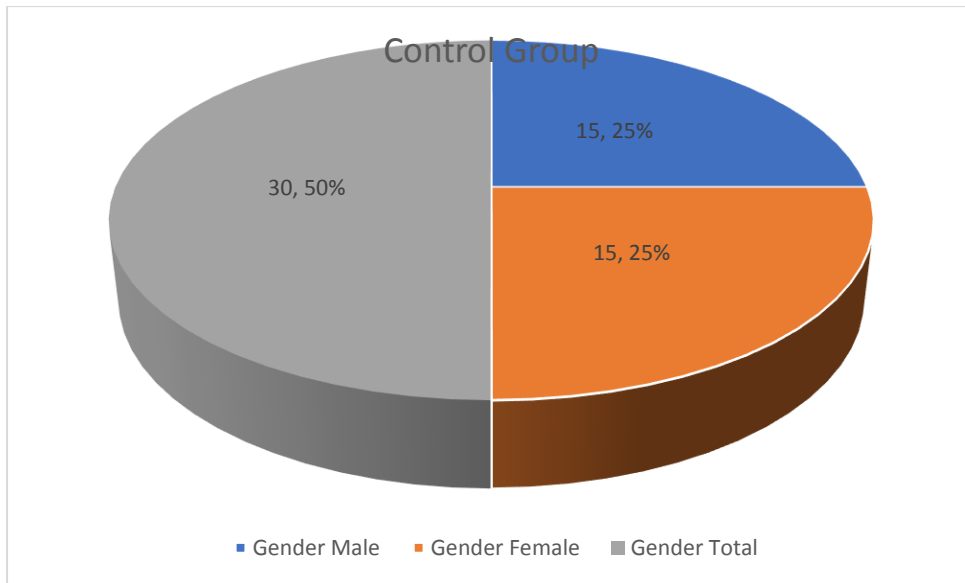


Figure 3.4 Showing Control group details based on Gender

3.5.2.3 Socio Economic Status.

The Socio-Economic Status of the subjects was recorded using the Socio-Economic Status Scale-Revised by Kuppaswamy, 2012 (Real time update). Table 3.5 Shows the frequency of the Socio-Economic Status of the sample. The socio-economic status is divided into five categories: Lower middle, Upper, Upper Lower, and Upper middle socio-economic status. The socio-economic status distribution is shown as a frequency polygon in Figure 3.5 below.

Table 3.5
Showing the Socio- Economic Status of the sample

	Frequency	Percent
Lower middle	15	25.0
Upper	7	11.7
Upper lower	18	30.0
Upper middle	20	33.3
Total	60	100.0

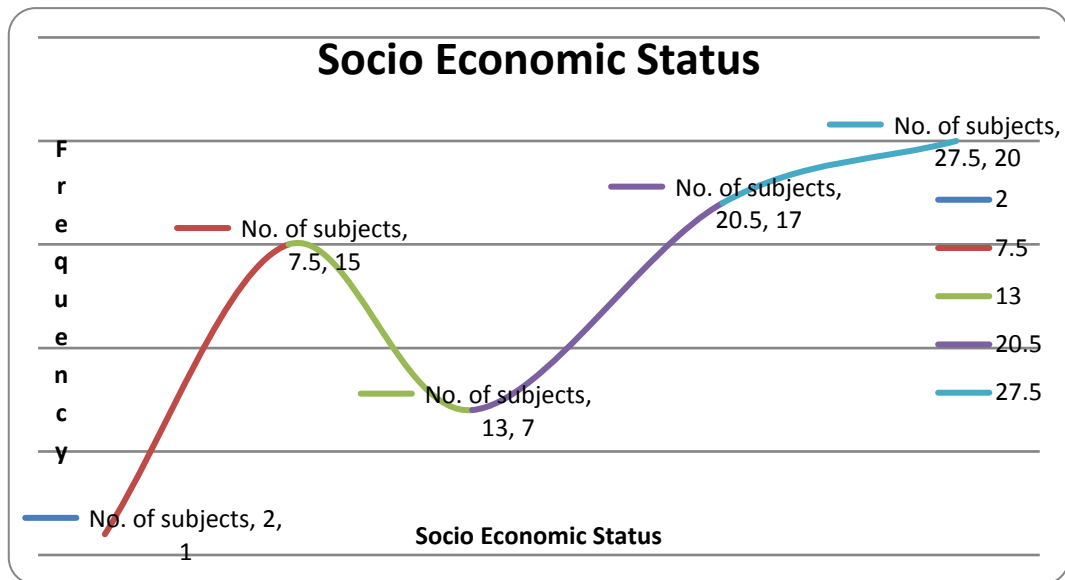


Figure 3.5 Showing the distribution of the Socio-Economic Status of the college students

3.6 Participants

The participants for the present study were selected using the purposive and convenience sampling technique. The students having mild to moderate depression/anxiety were selected by putting a notice or through the reference to teachers or classmates. The college students who volunteered to participate in the research were administered the Beck's Depression Inventory and Beck's Anxiety Inventory. The students, who met the criteria for inclusion, were selected. 30 males and 30 females with the criteria of inclusion were selected. From the total 30 males, 15 were randomly assigned to experimental group and 15 were assigned to the control group by using the snowball method of random sampling. Similarly, from 30 females, 15 were assigned to experimental group and 15 to control group.

Criteria of inclusion

The following were the criteria of inclusion into the sample:

1. Should be college student
2. Should be between 18 and 23 years of age

3. The depression or anxiety score should fall in the category of mild to moderate.
4. Should not be taking any psychotropic medicine or psychiatric treatment.

Criteria of exclusion

The following are the criteria of exclusion:

1. The depression or anxiety score falls in low or high category.
2. Is not attending any college.
3. Is taking some psychotropic medicine or psychiatric treatment.
4. Has age less than 18years or more than 23 years.

3.7 Schematic Representation of Research Design

The research design for the present study is shown as below:

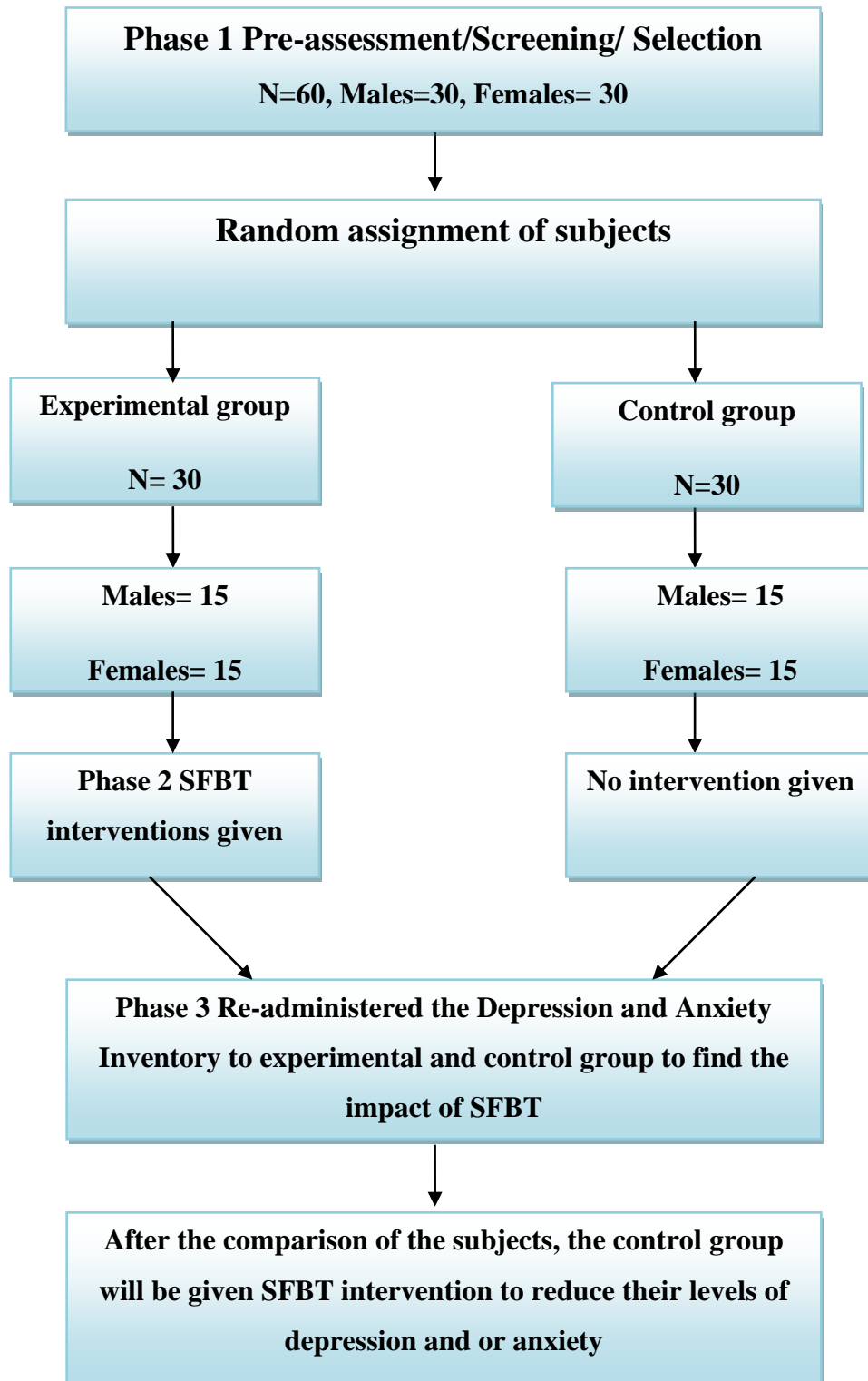


Figure 3.6 Showing the step by step design of the study

3.8 Measures

The present study is a quasi-experimental research to study the effectiveness of SFBT on anxiety and depression in college students. To meet this aim, standardized tools with high reliability and validity were used. In this study the following questionnaires were used to gather data from the participants:

3.8.1 Personal Data Sheet (Developed by the researcher).

A semi-structured questionnaire which included the required information of the participants was administered to the selected sample. It included items to collect the necessary information like the name, gender, age, class, religion, literacy of the parents, socio-economic status etc. The so collected demographic data forms an important aspect of the study.

3.8.2 Socio-Economic Status Scale-Revised by Kuppuswamy, 2012.

Socio-economic influences the well-being and the lifestyle of the subjects. The Kuppuswamy Socio-Economic scale was used to know the socio-economic strata of the subject. In order to keep in pace with the modern lifestyle and the ever-increasing inflation, the CPI(W) of the study as on 16th August, 2018 was taken. It includes three questions pertaining to the educational level of the head of the family of the subject, occupation of the head of the family and the family income that is categorized keeping the CPI (W) into consideration. In this way it uses real time update tool to classify the socio-economic status.

3.8.3 Beck's Anxiety Inventory by Aaron T. Beck (1990).

The Beck's Anxiety Inventory developed by Aaron, T. Beck was used to assess anxiety in the present study. This inventory is a 21-item self-report scale that measures the anxiety levels in adolescents and adults. Each item of the scale has four options varying from not at all, mildly, moderately to severely. Each answer is scored from 0 to 3. The range of the score is 0-63. The scores can be categorized as negligible for 0-7, mild for 8-15, moderate for 16-25 and serious for 26-63. The present study included the subjects with the score range of 8-25 i.e. from mild to moderate.

Psychometric Properties

Reliability: The internal consistency reliability estimated through Cronbach's alpha comes out in the range of 0.92 to 0.94 and test-retest reliability with a gap of one week comes out to be 0.75.

Validity: The concurrent validity is 0.51 with Hamilton Anxiety Rating Scale Revised. The validity comes out to be 0.58 for the state and for the Trait subscale 0.47 (State-Trait Anxiety Inventory. Form Y).

3.8.4 Beck's Depression Inventory by Aaron T. Beck (1996).

The Beck's Depression Inventory (BDI) was used to measure the variable depression in this study. This inventory is a self-report paper – pencil measure with 21 items. The items are scored from 0 to 3. The range of the score is 0-63 further categorized into 0-10 minimal range, 11-16 mild, 17-20 borderline, 21-30 moderate, 31-40 as severe and over 40 as extreme. It normally requires 5-10 minutes to complete. It is suitable for age above 13 years. It is an appropriate index of depression symptoms as per the DSM IV.

Psychometric properties

Reliability: The reliability of Beck's Depression Inventory (BDI) was calculated on the basis of two samples. One sample was of 500 outpatients from United States of America and the second one was of 120 college students. The internal consistency reliability using Cronbach's alpha came out to be 0.93 for the 1st sample and 0.93 for the 2nd sample. Significant correlations at $\alpha = .05$ were found on item total correlations for both the samples. For different items the correlations ranged from 0.39 (for Loss of Interest in Sex) to 0.70 (Loss of Pleasure) whereas for the college student population the item total correlations came out to be 0.27 (Loss of Interest in Sex) to 0.74 (Self-Dislike). Some other studies have found internal consistency coefficient in the range of 0.89 to 0.93 for Beck's Depression Inventory (Steer & Clark, 1997; Whisman, Perez, & Ramel, 2000; Wiebe & Penley, 2005)

Test-retest Reliability: The Beck's Depression Inventory has a split-half reliability of 0.93.

Validity: The correlation of BDI (II) with BDI (I)A came out to be 0.93 which is quite high (Arbisi, 2001). The validity of the Beck's Depression Inventory has a validity of 0.71 with Hamilton Psychiatric Rating Scale for Depression (HRSD-R). (Community-University Partnership for the Study of Children, Youth and Families, 2011).

3.9 Procedure

The three phases of the study can be enumerated as follows:

1. Pre-test/ Screening/Selection
2. SFBT intervention
3. Post assessment

3.9.1 Pre-assessment or Pre-test.

The first phase of the study involved the screening of the subjects with mild to moderate depression/anxiety. For this the participants studying in the college in the age group of 18-23 years were administered personal data sheet, Beck Anxiety Inventory, and Beck Depression Inventory. The participants with mild to moderate depression/anxiety were considered for the study. The selected participants were randomly assigned to experimental and control group.

3.9.2 SFBT intervention.

The 30 participants who were selected for the experimental group included 15 males and 15 females. They were given solution focused brief therapy popularly called SFBT. The SFBT intervention is a psychotherapeutic technique which focuses on solutions rather than the causes of the problems. The therapy mainly progresses on the basis of optimistic approach and is based on the premise that individuals are equipped with skills to solve their problems. The therapy looks at the individual as rational being who can re-channelize his resources to solve the problems. The therapist helps the individual in need, to change his perspective from problem to focus on solution. It aims to develop practical and quick solutions to gain lasting relief to clients.

SFBT works by helping people recognize their ability to solve the problems. It is based on the assumption that every individual has the skill to accomplish a change in his/her life. Therapist has to just help in focusing on the existing problems and

anticipated goals to mobilize the resources/skills towards solution. This goal is achieved by asking question to guide the session. The questions pertain to resilience ability and tools which can help them face life challenges. Such questions work like a miracle in helping the person recognize their ability and acknowledge the capability to solve the problems. Miracle questions make the people visualize life without problem; help in identifying small things that can help make a change. The main challenge lies in how to make the client visualize a better life in such a way that it can serve as a motivator for desiring and working towards that ideal situation. The visualization of problem-free life acts as a motivator to solve problems. Researchers have found SFBT to be successful with the problems of youth like academics/school related; family and couple counseling.

The main steps of therapy include searching and finding solutions, helping the client in imagining the situation he/she wishes to attain, making him/her realize that how that change can be made real. The past or history of the client is not considered to be important. The whole attention is paid to the desired state, hurdles to that desired state and using all available resources to cross the hurdles to reach their goal. The focus is crossing the hurdles and not removing the hurdles. SFBT is based on the assumption that the client has the capacity to imagine a change, will leave no stone unturned to reach the goal and the whole or part of change will start happening immediately (Weiner-Davis, de Shazer, & Gingerich, 1987). The therapy is very short and ends when the scaling by the subject is high or the client feels confident enough to terminate the sessions

In the present study, SFBT intervention was given by trained counselor and the sessions were conducted as per the norms laid down in the manual. The experimental group subjects were called for one to one interaction as per their convenience. As intervention involves personal talks so the subjects were assured of confidentiality. The session I started with rapport building. The client was asked how the therapist can be of help/ what does the client expect from this meeting. This first question helped in knowing what the client wanted to change. In other words, this first question helped in revealing the main concerns of the client. The counselor then asks about the difference the interaction will make or the counselor introduces the miracle question. The miracle question is like making the client divert from the problems to a better life

or life of one's desire. The question is framed on the basis of the belief of the client. If the client is religious the question can be like if God has listened to your prayers, and when you are napping, a miracle happens. If the client is not religious and believes in hard work, then the question can be something like with your hard work what maximum you can think of attaining or what will be the ideal type of life you want from your hard work. Once the client is able to answer the miracle question, then the counselor can move towards the exceptions question. The exceptions question is like asking the client about any situation of recent experience which is somewhat similar to the miracle just imagined. The exception question makes the client look for positive moments in his/her life. The process of answering the exceptions question shifts the focus of client from focusing on the problems in one's life to the good moments in his/her life. While answering this question, a sudden change in the client's expression is noticed for some subjects. They even remarked that before this moment, they had never realized the positives in their life. The counselor can also observe the change in facial expressions and the body language. After talking about the exceptions, the client is asked to do scaling. The scaling is like asking the client to tell how close the things are to miracle. This question is split into three aspects i.e. scaling of the pre-session change, scaling of the willingness to work to attain the miracle like situation and the confidence that the desired changes can be brought with effort. After the scaling, feedback is given to the client as compliments. It involves telling the client that he/she is doing good in the situation he/she is. At the same time along with compliments the bridging is done. This involves moving on to suggestions from feedback with the help of bridging statements. The client is suggested to do more of what works. In other words, while narrating the exceptions, the client has attained some awareness of the moments which are close to the desired situation. From that exception, the client is made aware of the skills which help in that accomplishment. So, during feedback the client is advised to do more of what works.

In this way, the first session is completed. At the end of the session, client is also asked about when he/she would like to meet again. The client can choose the next meeting as per his/her choice.

After completing the first session, the major base is laid down. The future sessions begin with “What’s Better?” The counselor listens carefully to the answer and does some amplification by asking “How did that happen?” or “How have you done this?” The subject is given reinforcement with some compliments or positive statements. Then the counselor proceeds with knowing what else was better. The clients answer whatever change he/she observes. The counselor advises to do more of whatever makes a change. From here the counselor moves on to scaling progress, compliments and feedback. This way the sessions continue till the client feels confident enough and wants termination. The counselor also observes the client’s non-verbal behavior and once finds the client to be confident, termination is done.

3.9.3 Post Assessment.

After the completion of the SFBT intervention on the subject of the experimental group, the subjects of both the experimental and control group were re-administered the Beck Anxiety Inventory and Beck Depression Inventory. The group data was pooled, and statistical tools were used to infer and compare the group data.

3.10 Ethical Issues

The study involving humans as subjects has to be done with care as human subjects cannot be denied any of their rights. The issues related to the rights of the human subjects are called ethical issues. The ethical issues are taken care of as follows:

- Written consent for participation in the research was taken. No participant was forced to participate in the study.
- The group was assured well in time of the confidentiality of all the information.
- There was no discrimination on the basis of gender, religion, education, socioeconomic status. The subjects were randomly assigned to the groups.
- The subjects were given unconditional positive regard and dealt with respectfully.
- The subjects were given autonomy and could leave the study at any time.

- They were assured that their identity will not be revealed. The data collected in this study will be used in such a way that the identity of the clients will not be revealed.

3.11 Statistical Analysis

The obtained data was probed, scored as per the scoring keys and was subject to the following statistical treatments.

1. The data collected was analyzed using descriptive statistics such as frequency, mean, and Standard Deviation.
2. Independent t-test was used to examine the significant group (Control and Experimental) and gender (Male and Female) differences in anxiety and depression.
3. To study the effect of SFBT on anxiety and depression paired sample t-test was applied.
4. The effectiveness of Solution Focused Brief Therapy on Anxiety and depression was examined by applying Repeated Measures ANOVA of General Linear Model.
5. One-way analysis of variance (ANOVA) was used to find out the significant differences in subjects' anxiety and depression with respect to their socio-economic status.

CHAPTER 4

RESULTS AND DISCUSSION

This is a quasi-experimental research. The aim of the present research was to see the effect of solution focused brief therapy on anxiety/depression among college students. The purposive and convenient method of sampling were used. The college students were administered the depression inventory i.e. Beck's Depression Inventory and Beck's Anxiety Inventory. The students who fell in the category of mild to moderate depression/anxiety constituted the sample. 30 males and 30 female students were included in the sample. From among the 30 males, they were randomly assigned to experimental and control group. Similarly, of the 30 female students, 15-15 were assigned randomly to the experimental and control group. The experimental group was given solution focused brief therapy and on average after 3 sessions, the Beck's Depression Inventory and Beck's Anxiety Inventory was re-administered to the experimental group. The control group was also re-administered the Beck's Depression Inventory and Beck's Anxiety Inventory after the passage of time equivalent to the time taken by the experimental group to complete the intervention. The group data was pooled, and the appropriate statistical tools were applied using SPSS to compute and interpret the results.

The analyses of the data was done by descriptive statistics mean and standard deviation, independent sample t-test for the experimental and control groups, paired t-test for a repeated measure of experimental and control group after intervention. The effect of Socio-economic status and age has also been shown. The results are tabulated along with graphical representation.

The pre-therapy independent sample t-test for anxiety and depression is discussed in the first section as this show the experimental and control groups equivalence before the intervention.

The second section deals with the post-therapy statistical inferences. This includes the interpretation of paired t-test of depression and anxiety before and after the intervention.

The results are discussed along with graphical representations; and interpretations with supporting studies are given.

4.1 Pre-therapy Analysis

4.1.1 Anxiety.

To measure the subject's anxiety level standardized tool was used and scores were statistically analyzed and shown in the following table with description.

Table 4.1

Showing the Mean, standard deviation, independent sample t-value and its significance for Anxiety before therapy of the Experimental and Control group (N=30)

Variable	Group	N	Mean	SD	t-value	p-value
Anxiety	Experimental	30	22.13	8.464	-0.135	0.893
	Control	30	21.80	10.545		

The Table 4.1 shows the mean, standard deviation, independent sample t-test along with its p-value of experimental and control group for anxiety before Solution focused brief therapy intervention. From Table 4.1 it is evident that the mean of the experimental group is 22.13 which is slightly more than the control group mean 21.80 with a standard deviation of 8.464 and 10.545 respectively. The t-value comes out to be -0.135. As the t-value is not significant (p-value= 0.893 > .05) so this can be interpreted as reflecting that there is no significant difference between the anxiety levels of experimental and control group before the intervention. Fig no. 4.1 shows the means of the anxiety of experimental and control group graphically. As the slope of the line is less, it reflects the same as above the small difference between the mean anxiety of the experimental and control group.

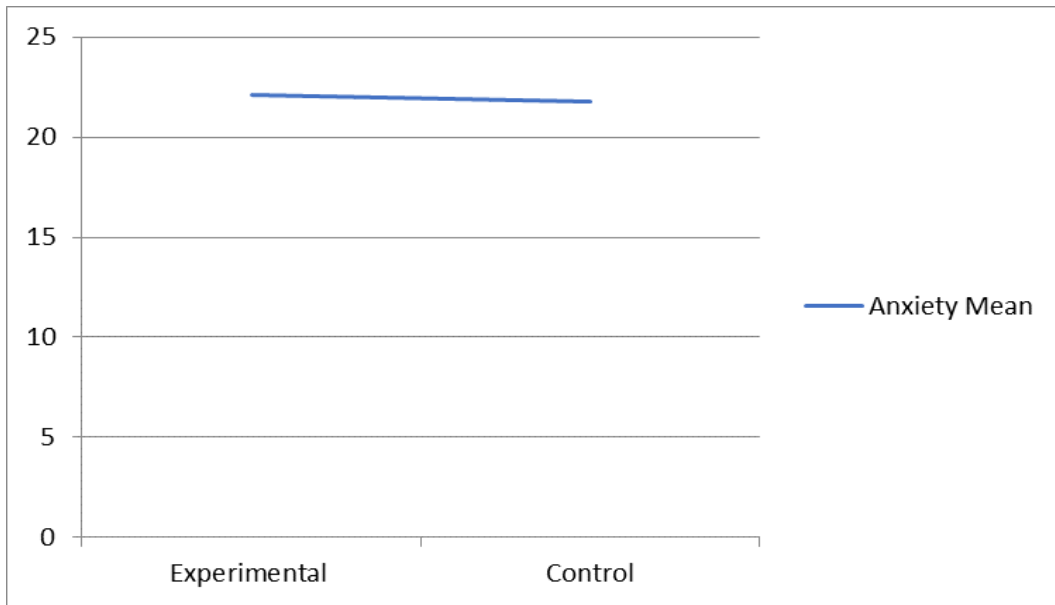


Figure 4.1 Showing the average of Anxiety scores of experimental and control group

4.1.2 Depression.

The depression was measured using Beck’s Depression Inventory. In the first step i.e. pre-test the score on BDI was recorded for both the experimental and control groups.

Table 4.2

Showing the mean, standard deviation, independent sample t-value and its significance for depression of experimental and control group (N=30)

Variable	Group	N	Mean	SD	df	t-value	p-value
Depression	Experimental	30	19.27	5.699			
Pre therapy	Control	30	20.33	6.651	58	0.667	.507

Table 4.2 shows the mean, standard deviation, independent sample t-value and its significance for depression of experimental and control group. The table reflects that the mean for depression of experimental group is 19.27 with standard deviation of 5.699 and of control group the mean is 20.33 with standard deviation of 6.651. Independent sample t-value calculated to see the significance of the difference between the means of experimental and control group reveals that the difference is not significant as the value of $t = 0.667$ with p-value 0.507 is less than 0.05. So, before

therapy the experimental and control groups were almost similar on the dimension of depression. Figure 4.2 shows the Line graph of the experimental group and control with depression mean. The line of depression mean has a very less slope indicating a non-significant difference between the two means.

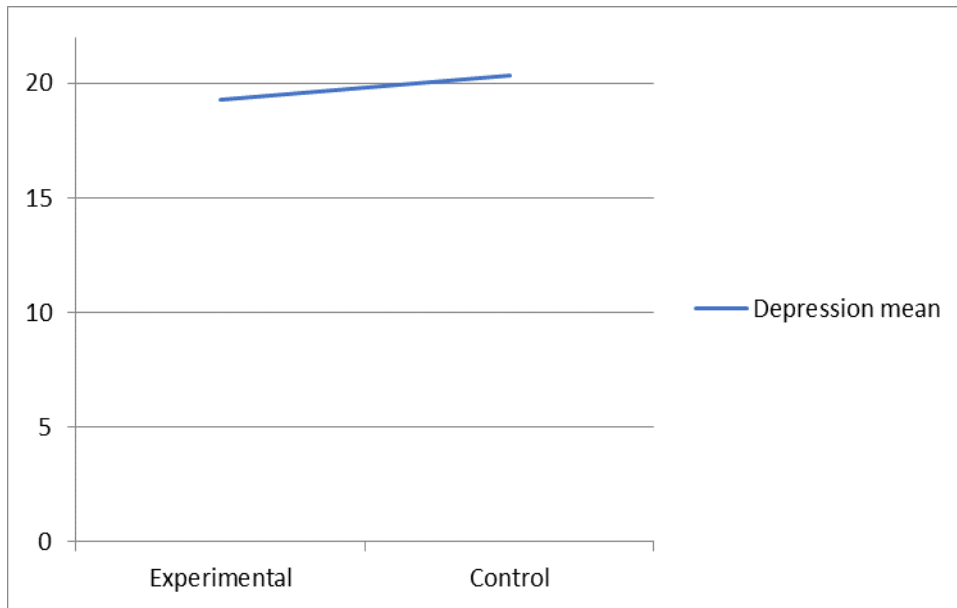


Figure 4.2 Showing the mean of depression of experimental and control group

4.2 Post –therapy Analysis

After giving Solution focused brief therapy as an intervention for depression and anxiety for experimental group, the subjects were administered Beck’s Depression Inventory for assessing depression and Beck’s Anxiety Inventory for assessing anxiety to both the experimental and control groups. The scores for both the groups are tabulated along with the descriptive and graphical representations.

4.2.1 Anxiety.

The scores on Beck’s Anxiety Inventory for the second stage, i.e. after the intervention stage are shown below along with the mean, SD and change in mean for both the experimental and control group bifurcated into males and females.

Table 4.3

Showing the Descriptive details of the pre- and post- therapy experimental and control groups on Anxiety.

Group	Gender	N	Pre-test		Post-test		Change in the
			Mean	SD	Mean	SD	mean value
Experimental group	Males	15	24.67	8.92	8.13	5.86	16.54
	Females	15	19.6	7.41	8.47	4.34	11.13
	Total	30	22.13	8.46	8.3	5.07	13.83
Control group	Males	15	20.27	11.82	17.47	8.66	2.8
	Females	15	23.33	9.24	21.4	9.58	1.93
	Total	30	21.8	10.54	19.43	9.19	2.37
Total	Males	30	22.47	10.53	12.8	8.68	9.67
	Females	30	21.47	8.44	14.93	9.83	6.54
	Total	60	21.97	9.48	13.87	9.26	8.1

Table 4.3 shows the descriptive test data for the experimental and control groups on anxiety. As evident from the table there is a difference of 13.83 between the mean score of anxiety before and after intervention for the experimental group. On the other hand, the mean difference is only about 2.37 for the control group which was tested twice but not given any intervention. The Table 4.3 also shows the experimental and control group mean and SD on the basis of gender. The comparison of the effect of intervention on different genders shows that males seemed to benefit more than the females as the mean has dropped from 24.67 before therapy to 8.13 after therapy for males and dropped from 19.6 to 8.47 for females respectively. These results have been shown graphically in Figure 4.3. This figure clearly shows that there is a considerable difference in the mean score of males, females, and total mean before and after treatment for the experimental group. Whereas there is not much difference in the mean score of anxiety on the two scores taken after a period of time for the control group.

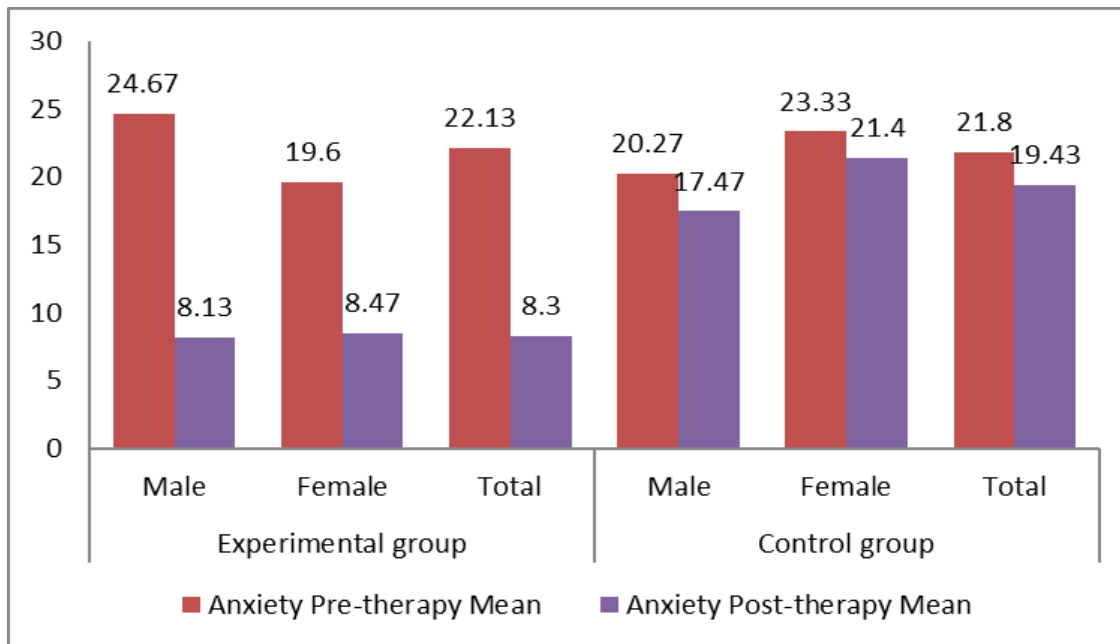


Figure 4.1 Showing the Mean and SD scores of Experimental and Control group on Anxiety

Table 4.4

Showing the Independent sample t-test value on anxiety for the experimental and control group on retesting after intervention.

Variable	Group	N	Mean	SD	t-value	df	p-value
Anxiety	Experimental	30	8.30	5.073	5.805	58	0.000
	Control	30	19.43	9.198			

The Table 4.4 shows the independent sample t-test value on anxiety for the experimental and control group on retesting after solution focused brief therapy intervention to the experimental group. The t-value comes out to be 5.805 at df=58. As the p-value is 0.000 which is less than 0.01, this implies that there is a significant difference between the experimental and control group after solution focused brief therapy intervention was given to experimental group. Before the treatment, there was no significant difference between the mean score of experimental and control group on anxiety as shown in Table 4.1. So, the change of t-value from not significant to significant after intervention for the same experimental and group subjects indicates the effectiveness of solution focused brief therapy.

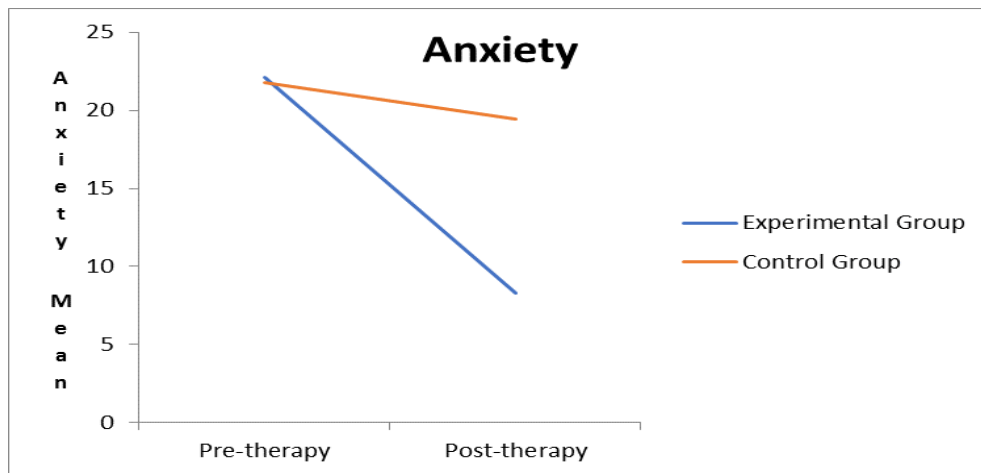


Figure 4.4 Showing the comparison of Pre and Post therapy mean of Experimental

Figure 4.4 shows the comparison of Pre and Post therapy mean of Experimental and Control group on Anxiety. Hence, solution focused brief therapy was effective in reducing the mean anxiety of the experimental group.

4.2.2 Depression.

The scores on Beck's Depression Inventory for the second stage, i.e. after intervention stage are shown below along with the mean, SD and change in mean for both the experimental and control group bifurcated into males and females.

Table 4.5

Showing the pre- and post-therapy mean, SD and change in mean value for the experimental and control group of Depression

Group	Gender	N	Pre-test		Post-test		Change in the
			Mean	SD	Mean	SD	mean value
Experimental group	Males	15	22.07	4.86	5.13	3.56	16.93
	Females	15	16.47	5.18	4.00	2.26	12.47
	Total	30	19.27	5.69	4.57	2.99	14.7
Control group	Males	15	19.53	6.76	19.87	10.0	-0.33
	Females	15	21.13	6.67	20.00	7.67	1.13
	Total	30	20.33	6.65	19.93	8.76	0.4
Total	Males	30	20.80	5.92	12.50	10.52	8.3
	Females	30	18.80	6.33	12.00	9.85	6.8
	Total	60	19.80	6.16	12.25	10.11	7.55

The Table 4.5 shows the descriptive test data for the experimental and control groups on depression. As evident from the table there is a significant difference of 14.7 between the mean score of depression before and after intervention for the experimental group. On the other hand, the mean difference is only about 0.4 for the control group which was tested twice but not given any intervention. The table 4.5 also shows the experimental and control group mean and SD on the basis of gender. The comparison of the effect of intervention on different genders shows that males seemed to benefit more than the females as the mean depression of males decreased from 22.07 to 5.13 with a change of 16.93 in the mean value and the females mean depression reduced from 16.47 to 4.00 with a change of 12.47 in the mean value. As the fall in the mean value is more for males than the females so, males seemed to benefit more. These results have been shown graphically in Figure 4.5. The comparison of the mean score of male, female and total before and after treatment is shown for both the experimental and control groups below. This figure clearly shows that there is a considerable difference in the mean score of male, female and total mean before and after treatment for the experimental group. Whereas there is not much difference in the mean score of depression on the two scores taken after a period of time for the control group.

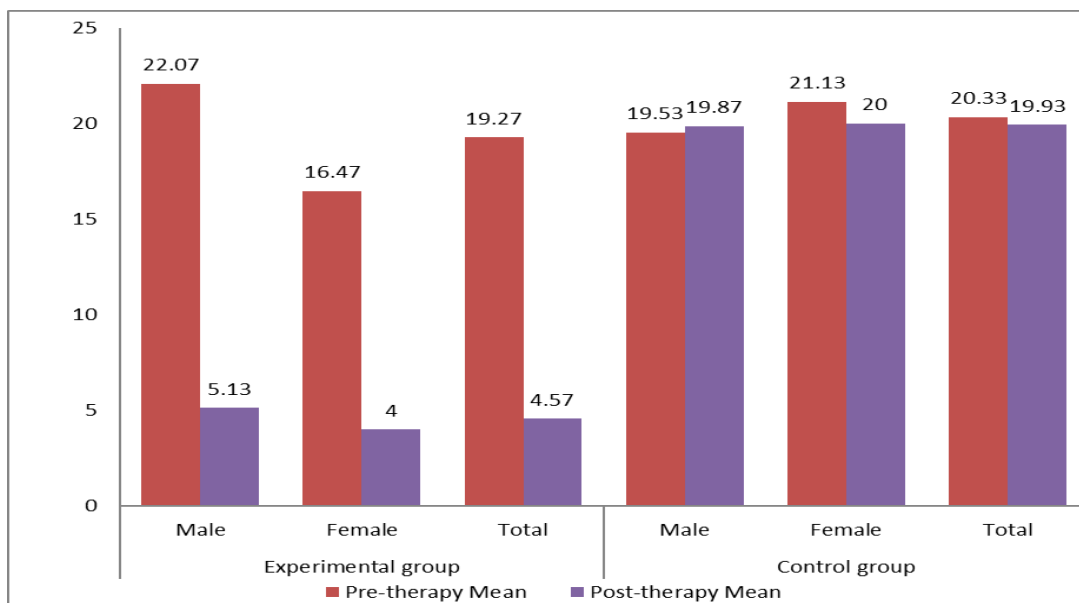


Figure 4.5 Showing the Depression mean pre- and post- therapy for male and female for both experimental and control group

Table 4.6

Showing the Independent sample t-value for the experimental and control group on depression.

Variable	Group	N	Mean	SD	t-value	df	p-value
Depression	Experimental	30	4.57	2.991	9.092	58	0.000
	Control	30	19.93	8.761			

The Table 4.6 shows the independent sample t-test value on depression for the experimental and control group on retesting after solution focused brief therapy intervention to the experimental group. The t-value comes out to be 9.092 at df=58. As the p-value is 0.000 which is less than 0.01, this implies that there is a significant difference between the experimental and control group after solution focused brief therapy intervention given to experimental group. Before the treatment, there was no significant difference between the mean score of experimental and control group on depression as shown in Table 4.2.

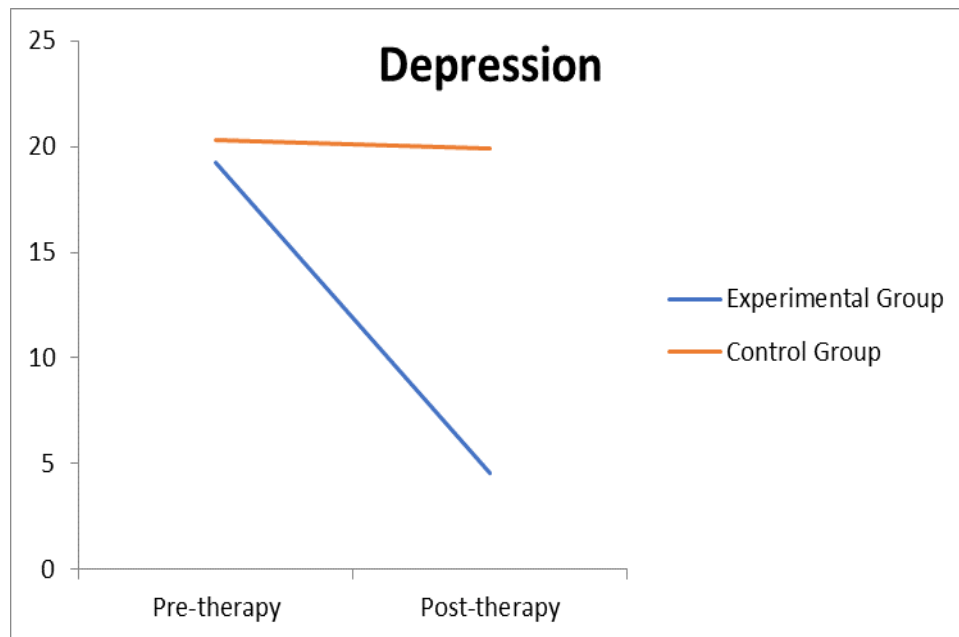


Figure 4.6 Showing comparison of pre and post therapy mean of experimental and control group on depression

Figure 4.6 shows the comparison of pre and post therapy mean of experimental and control group on depression. So, the change of t-value from not significant to

significant after intervention for the same experimental and control group subjects indicates the effectiveness of solution focused brief therapy.

4.3 Results in The Light of Hypotheses

The following section shows the statistical analysis in the light of the hypotheses of the research:

4.3.1 Hypothesis 1: Solution-focused brief therapy will have a positive impact in reducing the level of anxiety in college students.

In order to test this hypothesis, paired sample t-test was used to compare the pre therapy and post therapy scores on anxiety and depression.

4.3.1.1 Paired sample t-test for anxiety of Experimental Group.

Table 4.7

Mean differences of pre and post-test with respect to anxiety

Variable	Test	N	Mean	Std. Deviation	df	t	Sig.
Anxiety	Pre	30	22.13	8.46	29	7.87	.000
	Post	30	8.30	5.07			

Table 4.7 showing mean differences of pre and post-test with respect to anxiety. From the table, it can be seen that the t-value 7.979 at $df = 29$ is significant as $p < 0.01$. This implies that the introduction of solution focused brief therapy brought about a significant change in the anxiety scores of the experimental group.

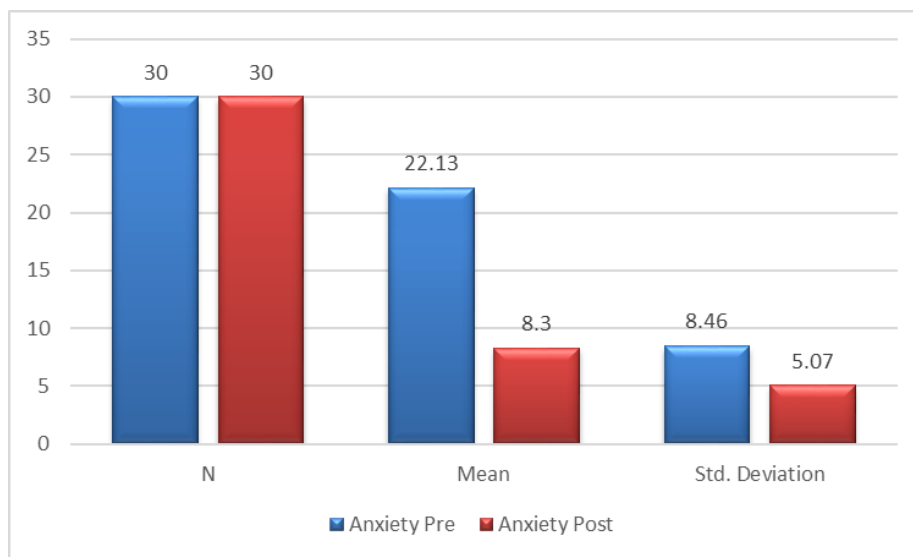


Figure 4.7 Means and Standard deviation of Pre and Post therapy Experimental group with respect to Anxiety

The Figure 4.7 showing the mean and standard deviation of Pre and Post therapy Experimental group with respect to anxiety. The figure shows that the mean of experimental group reduced from 22.13 to 8.3 with standard deviation reduced from 8.46 to 5.07.

4.3.1.2 Repeated Measures ANOVA for Anxiety.

The paired t-test for anxiety yielded significant results for the effect of solution focused brief therapy on the experimental group. In order to make further analysis, repeated measures analysis of variance was done for anxiety.

Table 4.8
Showing Repeated measures ANOVA for Anxiety (Tests of Within-Subjects Effects)

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Therapy	Sphericity Assumed	2870.41	1	2870.41	62.07	.000	.68
	Greenhouse- Geisser	2870.41	1.00	2870.41	62.07	.000	.68
Error (Therapy)	Sphericity Assumed	1341.08	29	46.24			
	Greenhouse- Geisser	1341.0	29.00	46.24			

The Table 4.8 Showing Repeated measures ANOVA for anxiety. From the table it can be inferred that the therapy effect is statistically significantly different from pre therapy to post therapy anxiety score $F(1, 29) = 62.071$, $p < .01$, partial $\eta^2 = .682$. So, the therapy elicited statistically significant changes in anxiety. Hence, there was statistically significant difference between the means before and after therapy. So, the hypothesis stating that Solution Focused Brief Therapy will have significant impact on anxiety is accepted. As the results are significant at 0.01 level, so if the experiment is repeated, there are 99 out of 100 chances of getting similar results.

4.3.1.3 Paired sample t-test for anxiety of Control Group.

The paired sample t-test was done for anxiety of control group to know whether passage of time brought about any change in anxiety of the control. The control group did not receive any intervention or treatment.

Table 4.9

Mean Difference of pre and post therapy test with respect to anxiety

Variable	Test	N	Mean	Std.Deviation	df	t	Sig.
Anxiety	Pre	30	21.80	10.55	29	1.362	.184
	Post	30	19.43	9.18			

Table 4.9 showing mean difference of pre and post-test with respect to anxiety of control group. The t-value 1.362 at df 29 is not significant as $p > .05$. So, there is no significant change in the anxiety scores of the control group over a period of time.

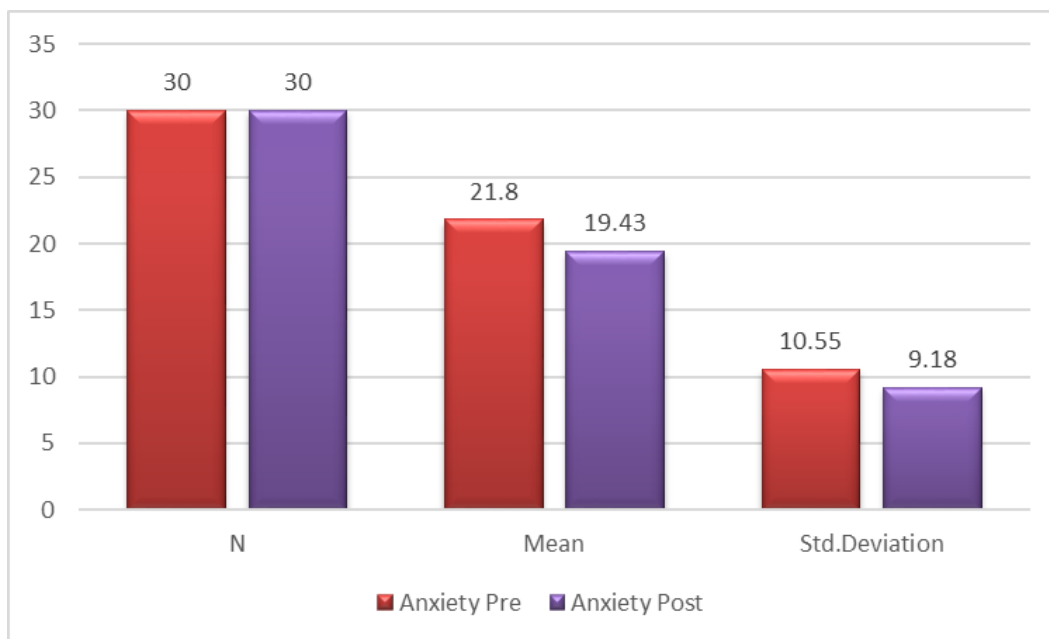


Figure 4.8 Mean and Standard deviation of Control group for Anxiety

Figure 4.8 showing the mean and standard deviation of control group for anxiety. The mean fell from 21.8 to 19.43 with standard deviation of 10.55 and 9.18 respectively.

4.3.2 Hypothesis 2: Solution-focused brief therapy will have a positive impact in reducing the level of depression in college students.

4.3.2.1 Paired sample t-test for depression of Experimental Group.

Table 4.10

Mean differences of pre and post test with respect to Depression

Variable	Test	N	Mean	Std. Deviation	df	t	Sig.
Depression	Pre	30	19.27	5.69	29	13.30	.000
	Post	30	4.57	2.99			

From Table 4.10 Showing mean differences of pre and post-test with respect to depression, it can be inferred that there is significant difference in the depression of experimental group from pre-test to post-test as the t-value 13.30 at df= 29 is significant $p < 0.01$. This suggests that the solution focused brief therapy intervention brought about a significant change in the depression score of the subjects of experimental group.

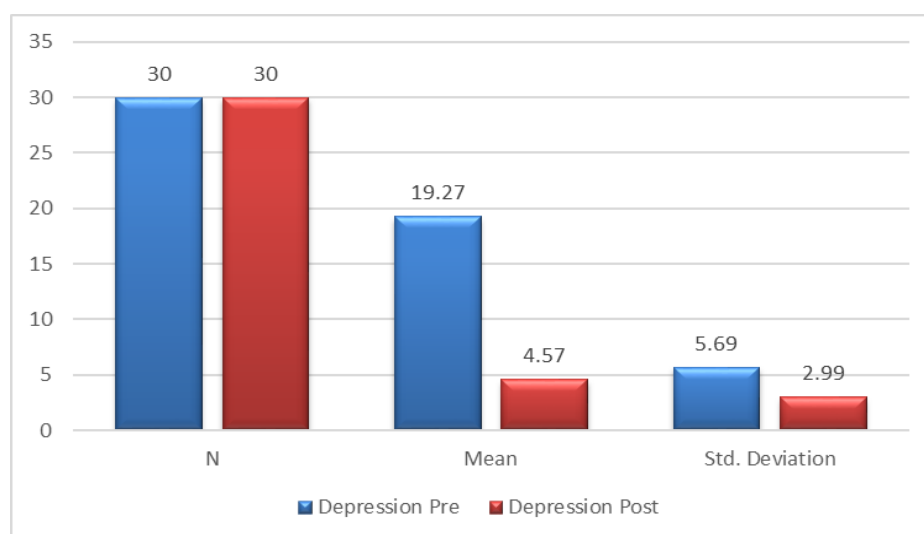


Figure 4.9 Mean and Standard deviation of Experimental group with respect to Depression

Figure 4.9 Showing mean and standard deviation of experimental group with respect to depression as a bar diagram. From the figure it is seen that the mean decreased from 19.27 to 0.57 with standard deviation from 5.69 to 0.99 respectively. The figure reflects a lower mean on depression of the experimental group post therapy.

4.3.2.2 Repeated Measures ANOVA for Depression.

The paired t-test for depression indicated significant results for the effect of solution focused brief therapy on the experimental group. In order to make further analysis, repeated measures ANOVA was done for depression.

Table 4.11
Showing Repeated measures ANOVA for Depression

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	
Therapy	Sphericity Assumed	1804.01	1	1804.01	54.46	.000	.65
	Greenhouse-Geisser	1804.01	1.00	1804.01	54.46	.000	.65
Error (Therapy)	Sphericity Assumed	960.48	29.00	33.12			
	Greenhouse-Geisser	960.48	29.00	33.12			

Table 4.11 shows the Repeated measures ANOVA for Depression. It is evident from the table that the therapy effect is statistically significantly different from pre therapy to post therapy depression score $F(1, 29) = 54.47, p < .01, \text{partial } \eta^2 = .65$. The therapy elicited statistically significant changes in depression. As there was statistically significant difference between the means before and after therapy and the hypothesis stating that Solution Focused Brief therapy will have significant impact on depression is accepted. If this procedure is repeated, then there are 99 chances of getting similar results.

4.3.2.3 Paired sample t-test for Control group on Depression.

The paired sample t-test was done for depression of control group to know whether passage of time brought about any change in depression of the control group. The control group did not receive any intervention or treatment.

Table 4.12
Mean differences of pre and post test with respect to Depression

Variable	Test	N	Mean	Std.Deviation	df	t	Sig.
Depression	Pre	30	20.33	6.65	29	.368	.715
	Post	30	19.93	8.76			

Table 4.12 showing mean difference of pre and post test with respect to depression of control group. The t-value 0.368 at df 29 is not significant as $p > .05$. So, there is no significant change in the depression scores of the control group over a period.

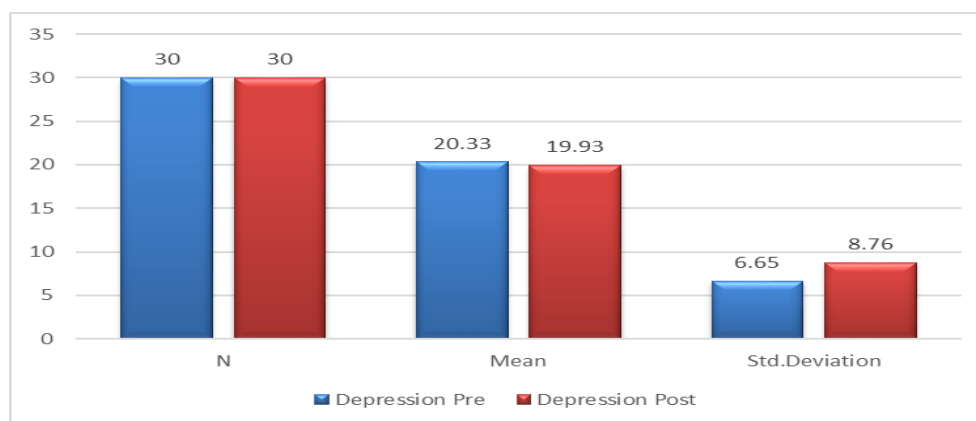


Figure 4.10 Showing Mean and Standard deviation of Control group for Depression

Figure 4.10 showing the mean and standard deviation of control group for depression. The mean fell from 20.33 to 19.93 with standard deviation of 10.55 and 9.18 respectively.

4.3.3 Hypothesis 3: Demographic variables will make a significant difference on anxiety, and depression in college students.

To see the effect of demographic variables on anxiety and depression in college students, independent samples t-test was done with respect to gender. To see the effect of socio-economic status on the anxiety and depression, one-way ANOVA was done.

4.3.3.1 Difference made by Gender on anxiety and depression.

Table 4.13

t-test independent samples for Gender differences

Variable	Gender	N	Mean	Std. Deviation	df	t-value	sig
BDI	Male	30	20.80	5.92	58	1.263	.616
	Female	30	18.80	6.33			
BAI	Male	30	22.46	10.53	58	.406	.245
	Female	30	21.46	8.44			
BDIPT	Male	30	12.50	10.51	58	.190	.704
	Female	30	12.00	9.85			
BAIPT	Male	30	12.80	8.68	58	-.891	.375
	Female	30	14.93	9.83			

From Table 4.13 it can be seen that independent sample t-test value for Depression between Male and Female participants is not significant (t-test value=1.263 at df= 58; $p > .05$ before therapy; t-test value = 0.190 at df = 58; $p > .05$ after therapy).

The t-test value for Anxiety before therapy is also not significant (t-test value=0.406 at df= 58; $p > .05$ before therapy; t-test value = 0.891 at df = 58; $p > .05$ after therapy).

4.3.3.2 Difference made by Socio Economic Status on anxiety and depression.

In order to see the difference made by socio-economic status on anxiety and depression one-way ANOVA was done.

Table 4.14
ANOVA for Socio Economic Status

		N	Mean	Std. Deviation	F	Sig.
BDI	LM	15	18.40	5.91	.496	.687
	U	7	20.42	5.74		
	UL	18	19.50	6.36		
	UM	20	20.90	6.52		
	Total	60	19.80	6.16		
BAI	LM	15	20.46	12.36	.711	.549
	U	7	21.14	8.93		
	UL	18	20.72	7.05		
	UM	20	24.50	9.30		
	Total	60	21.96	9.48		
BDIPT	LM	15	11.13	9.27	1.190	.322
	U	7	16.85	11.59		
	UL	18	9.50	7.84		
	UM	20	13.95	11.72		
	Total	60	12.25	10.11		
BAIPT	LM	15	12.20	7.13	.674	.572
	U	7	18.00	9.24		
	UL	18	13.11	10.69		
	UM	20	14.35	9.49		
	Total	60	13.86	9.26		

Table 4.14 shows ANOVA for socio economic status. The table reflects that there is no significant difference in anxiety on the basis of Socio-economic status. The value of F test is not significant (F value .496, .711, 1.190, .674 at df = 3, 56 has $p > .05$). From this it can be inferred that the differences made by the socio-economic status on anxiety and depression score of college students has been found to be not

significant. The impact of socio-economic status on the effectiveness of solution focused brief therapy was also studied. The table 4.14 shows that the one-way ANOVA of post therapy score i.e. BAIPT and BDIPT in relation to socio economic status is also not significant. So, it can be said that socio economic status did not produce any significant differences. Hence, the hypothesis stating that the Demographic variables will make a significant difference on anxiety, and depression in college students is rejected as no significant difference has been found on the basis of gender and socio-economic status.

4.4 Main Findings

The main findings from this research study can be enumerated as follows:

1. Solution focused brief therapy was effective in the reduction of anxiety in the college students.
2. Solution focused brief therapy was effective in the reduction of depression in the college students.
3. There is no difference made by gender on anxiety and depression score.
4. There is no difference made by socio economic status on anxiety and depression score.

4.5 Discussion

The purpose of the present study is to assess the effectiveness of Solution focused brief therapy on anxiety and depression in college students. Based on the design and objectives of the study, 30 males and 30 females in the age group of 18-23 years studying in a College in Bathinda region with mild to moderate anxiety or depression were selected and assigned randomly to the experimental and control group. They were administered anxiety and depression inventory for the pre-therapy score. The experimental group was given Solution focused brief therapy intervention for 3-5 weeks. The control group was not given any intervention. After the therapy, they were again administered the depression and anxiety inventory. The control group was also re-administered the depression and anxiety inventory. The pre-therapy and post-therapy scores were pooled and compared using the statistical tools to know the effectiveness of SFBT.

The objectives of the present study are as follows:

1. To study the impact of Solution-focused brief therapy on the level of anxiety.
2. To study the impact of Solution-focused brief therapy on level of depression.
3. To find out whether anxiety/depression in college students differs by the demographic variables gender and Socio-economic status.

On the basis of, these objectives, the following hypotheses were formulated:

Hypothesis 1: Solution-focused brief therapy will have a positive impact in reducing the level of anxiety in college students.

Hypothesis 2: Solution-focused brief therapy will have a positive impact in reducing the level of depression in college students.

Hypothesis 3: Demographic variables will make a significant difference in anxiety, and depression in college students

To meet the objectives of the study the data was collected using the clearly defined method and step by step procedure.

The statistical analysis of the pre-therapy scores shows that there is no significant difference between the experimental and control group before the introduction of any treatment. The t-value between the anxiety scores experimental and control group before the intervention comes out to be -0.135, which is not significant. It is evident that the experimental and control group are similar before the intervention on the variable of depression also. The t-value on the variable of depression is 0.667, which is not significant. These statistical results clearly imply that both the experimental and control group are statistically same on the variables of anxiety and depression.

The main aim of the present study is to see the effectiveness of solution focused brief therapy on the variables of depression and anxiety. So, the selected sample after being randomly assigned to experimental and control group is an important step to achieve

this aim. According to the design of the study, the experimental group is given SFBT intervention whereas the control group is for comparison of the effect of SFBT.

The SFBT intervention was given by trained counselor and the sessions were conducted as per the norms laid down in the manual. The experimental group subjects were called for one to one interaction as per their convenience. As intervention involves personal talks so the subjects were assured of confidentiality. The session I started with rapport building. The client was asked how the therapist can help/ what does the client expect from this meeting. This first question helped in knowing what the client wanted to change. In other words, this first question helped in revealing the main concerns of the client. The counselor then asks about the difference the interaction will make. The counselor then introduced the miracle question. The miracle question is like making the client divert from the problems to a better life or life of one's desire. The question is framed on the basis of the belief of the client. If the client is religious the question can be like if the God has listened to your prayers, and when you are sleeping, a miracle happens. If the client is not religious and believes in hard work, then the question can be something like with your hard work what maximum you can think of attaining or what will be the idle type of life you want from your hard work.

The previous studies have also found the miracle question to be like the heart of solution focused therapy and is rated as one of the distinguishing techniques it offers (Skidmore, 1993). The client's answer is to direct the progress of the therapy as it helps in specifying the desired goals and visualize the future life (de Shazer, 2002). The SFBT miracle question is introduced to achieve the different goals that include development and treatment, promote hope and prepares the client for exceptions (de Shazer, et al., 2007). Research has supported the attainment of these goals by SFBT: the miracle question has been found to elicit response about variety of issue which led to concrete, relational, and emotional/ affective progress and felt more confident after responding to the miracle question (Dine, 1995; Shilts, Rambo, & Hernandez, 1997); clarifies/ develops goals and identifies ways to accomplish those goals (Isherwood & Regan, 2005; Shilts, Flippino, & Nau, 1994).

Once the client is able to answer the miracle question, then the counselor can move towards the exceptions question. The exceptions question is like asking the client about any situation of recent experience which is somewhat similar to the miracle just imagined. The exception question makes the client look for positive moments in his/her life. The process of answering the exceptions question shifts the focus of client from focusing on the problems in one's life to the good moments in his/her life. While answering this question, a sudden change in the client's expression is noticed for some subjects. They even remarked that before this moment, they had never realized the positives in their life. The counselor can also observe the change in facial expressions and the body language. The exception questions shift the focus of the subject from the problems to the solutions. As narrated by the clients, they are most of the time occupied by the thoughts of the problem and hence unable to see the solution. In the counseling setting, when the client is asked about the time when the problem was less, the client looks back, narrates some time or event when the occupation with problem was less, and in this process the client realizes that there are times when the problem is not present. The further exploration of the event to find out what made the differences, helps the client become aware of his/her strengths or tools that help in bringing about the change. This is like the enlightenment that helps the client acquire tools and use them whenever they must bring about a change.

Other studies have also found that the presupposition questions help in communicating positive belief that raises hope in the client leading to expectations of something better in future and makes them self-confident of their ability to achieve the treatment goals (McKeel J. , 2012). The framing of the exception question plays a very important role. It has been found that solution focused therapist should ask "What has helped in dealing with this situation in the past?" instead of "Have you tried anything that worked?" The main difference between these two questions are that the first question reflects that the client has definitely been successful in dealing with the situation (O'Hanlon & Weiner-Davis, 1989). In this way the question is constructed in such a manner that it helps in promoting hope in the client, helps them in identifying their strength, capability, success and future possibilities (MacMartin, 2008; O'Hanlon & Weiner-Davis, 1989). The research done on presupposition

questions reflects that when positively constructed questions are asked from the client regarding pre-treatment change, 66.67% of clients reported improvements with details of the improvement (Weiner-Davis, de Shazer, & Gingerich, 1987); 60% clients reported pretreatment improvement in the replication of the same study (Lawson, 1994; McKeel & Weiner- Davis, 2009); 53% reported improvement in the questionnaires on presuppositional questions (Johnson, Nelson, & Allgood, 1998).

After talking about the exceptions, the client is asked to do scaling. The scaling is like requesting the client to tell how close the things are to a miracle. This question is split into three aspects i.e. scaling of the pre-session change, scaling of the willingness to work to attain the miracle like situation and the confidence that the desired changes can be brought with effort. The pre-session scaling is an index of the hope of the client. Research studies have found it to be quite a useful aspect of solution focused brief therapy. In the present study also, it was realized that scaling proved to be quite useful. When the counselor asked the client to scale or give a number to the change that is felt by them, the client becomes more focused. It is a well-established fact that the knowledge of the result has a positive impact on future efforts. So, the scaling in solution focused brief therapy is like giving marks or measure in numbers the change which can be felt till that time. On the one hand, it gives confidence to the client and on the other hand it gives hope with a clear-cut next step or objective.

Research has found pretreatment improvement in 30% cases (Allgood, Parham, Salts, & Smith, 1995); 15 percent improvement in problems before treatment (Howard, Kopta, Krause, & Orlinsky, 1986); the clients reporting pretreatment improvement have been found to complete the therapy successfully (Beybach, Morejon, Palenzuela, & Rodriguez-Arias, 1996; Johnson, Nelson, & Allgood, 1998); clients report pretreatment change when the therapist asks about it (Kindsvatter, 2006; McKeel & Weiner- Davis, 2009).

After the scaling, feedback is given to the client as compliments. It involves telling the client that he/she is doing well in the situation he/she is in. At the same time along with compliments the bridging is done. This involves moving on to suggestions from feedback with the help of bridging statements. The client is suggested to do more of

what works. In other words, while narrating the exceptions, the client has attained some awareness of the moments which are close to the desired situation. From that exception, the client is made aware of the skills which help in that accomplishment. So, during feedback the client is motivated to do more of what works. For example, one of the clients said that waking up early in the morning makes a happy home environment. So, the client was motivated to start waking up early. In this way, the first session is concluded. At the end of the client is also asked about when he/she would like to meet again. The client can choose the next meeting as per his/her choice.

After completing the first session, the major base is laid down. The future sessions begin with “What’s Better?” The counselor listens carefully to the answer and does some amplification by asking “How did that happen?” or “How have you done this?” The subject is given reinforcement with some compliments or positive statements. Then the counselor proceeds with knowing what else was better? The clients answer whatever change he/she observes. The counselor advises doing more of whatever makes a change. From here the counselor moves on to scaling progress, compliments and feedback. De Shazer found that compliments to the efforts made by the client helps in moving ahead towards the goals (de Shazer, 1982).

This way the sessions continue till the client feels confident enough and is ready for termination. The counselor also observes the client’s non-verbal behavior and once finds the client to be confident, termination is done.

The basic premise of the solution focused brief therapy is that one does not need to know the details of the problem to find the solution. What is more important is the positive orientation of the thought process or an expectation of something good (de Shazer, 1985). So, using SFBT the counselor does not dig into the details of the problems. Instead the counselor tries to ignite positive thoughts which are oriented at finding solutions.

After the termination, the subjects in the present research were re-administered Beck’s Depression Inventory and Beck’s Anxiety Inventory. The score so obtained are recorded as post-therapy scores.

The control group was also re-administered the Beck Depression Inventory and Beck's Anxiety Inventory after the passage of an equivalent amount of time. In the present study the counseling was completed in approximately 3-4 weeks.

The group data for the experimental and control group were pooled and statistical tools were applied to analyze the change if any. The changes in the mean of the experimental and control groups before and after the therapy. The change in mean of anxiety for the experimental group was 13.83 (16.54 for Males and 11.13 for Females) and for the control group was 2.37 (2.8 for Males and 1.93 for Females). There appears to be a quite large difference in the change of both the groups. To check the significant difference between the mean, t-value was calculated. The t-value for the experimental and control group on anxiety is 5.805 at $df= 58$ with a p-value of 0.000 which is significant at 0.01 level. This implies that previously similar groups were now significantly different. As the main difference between the two groups is the presence or absence of solution-focused brief therapy intervention, so it can be concluded that the solution-focused brief therapy was effective in reducing the anxiety of the college students.

When the experimental and control groups were compared on anxiety for pre-therapy and post therapy scores, the t-value comes out to be significant for experimental group (from table 4.10, t-value = 13.03, $df=29$ and p-value= 0.000 for depression and t-value= 7.879, $df= 29$ and p-value= 0.000 for anxiety from table 4.7).

The significance of the paired t-value of the experimental group for depression and anxiety clearly indicates that a significant difference was made by the solution-focused brief therapy. This implies that the SFBT has been quite effective for depression and anxiety among college students.

Solution focused brief therapy has been found to be quite effective in previous research also. Though this study of effectiveness of solution focused brief therapy on depression and anxiety has not been done before yet the review of literature on SFBT shows its effectiveness on different problems. Some of the studies are: comparing the mental health outcomes of **substance abuse clients** who were randomly assigned to the solution focused group therapy (SFGT) and Hazelden therapy and evaluated on

Beck Depression Inventory and OQ (Outcome Questionnaire) Symptom Distress subscale, concludes that Solution-focused group therapy lead to significant improvement on both the measures (Smock, et al., 2008).

One of the important studies reported by **Gingerich et al** (2012) is the one was done by **Knekt** (2008; 2008b) as it is one of the few studies fulfilling the criteria of having a large number of subjects i.e. 326 subjects, used a clear diagnostic criteria for including subjects, the subjects were randomly assigned to control and experimental groups, the therapist was well trained, the SFBT manual was used and adhered to, and comparison between two evidence based therapies i.e. short-term psychodynamic therapy (STPP) and long-term psychodynamic therapy (LTPP) was made. The study compared the mental health outcome of **depression and anxiety** patients receiving SFBT, STPP, and LTPP. The average number of sessions of patients receiving SFBT was 10 over a period of 8 months, those receiving STPP were 19 sessions over a period of 6 months and those receiving LTPP were 232 sessions over 31 months. The three years follow up of this study showed that all three therapies were almost equally effective outcome. The detailed analysis showed that the SFBT and STPP produced good results in 1 year and LTPP improvement was visible in 2 years which surpassed other therapy outcomes in the third year. There was no statistically significant difference in the outcome or gains of the three therapies. This study supports the effectiveness of SFBT in less time in comparison to the time taken by the other therapies to reach the same level of improvement.

Trepper and Franklin (2012) reported some studies where solution focused brief therapy yielded good results. Some of the studies are **on schools** (Kelly, Kim, & Franklin, 2008), **on domestic violence and abuse** (Lee, Seebold, & Uken, 2003), **substance abuse** (Hendrick, Isabaert, & Dolan, 2012), **on management and coaching** (McKergow, 2012), **child protection services** (Wheeler & Hog, 2012), **medication adherence** (Panayotov, Strahilov, & Anichkina, 2012), and **on adolescents** (Corcoran, 2012).

Bond, Humphrey, Symes, and Green (2013) examined the effectiveness of SFBT with **families and kids**. They also reported weak methodology as a major

reason for ineffectiveness on one hand and the success of SFBT with internalizing externalizing problem in children on the other hand.

Franklin and colleagues (2001) studied the effect of SFBT on externalizing problems among elementary school students. The results indicated an ineffective treatment for the hyperactivity index subscale was found to be 47.65 % which is considered ineffective. On the other hand, the subscale of Hyperactivity and Daydream Attention indicated mildly effective results. The Asocial and Conduct Problem reflected moderate effectiveness.

Yarborough (2004) studied the effect of solution focused brief therapy on completion of assignment and accuracy rate of work by six elementary school students. The results were found to be quite opposite for assignment completion and assignment accuracy. SFBT proved to be effective for assignment completion with a completion rate of 93.8% but ineffective for assignment accuracy with an accuracy rate of 0%.

Franklin et al (1997) found SFBT to be almost 100% accurate with adolescents. He measured the externalizing behavior problems in three adolescents using self-anchored scales and made them identify the behavior that they wanted to change during the sessions. The results reflected a 100% success rate proving the high effectiveness of SFBT.

Conoley et al (2003) studied the effectiveness of SFBT on the frequency of problems in three children who were diagnosed with oppositional aggressive behavior and on the basis of daily report of problem frequency by the parents found it to be yielding 0% results indicating the ineffectiveness of SFBT with such problems.

Jakes and Rhodes (2003) studied the effectiveness of SFBT on five adults having delusions and the results indicated minor improvement for conviction and negligible to zero percent for preoccupation and distress respectfully proving the therapy to be ineffective.

Franklin et al (2001) studied seven students with internalizing behaviors using the subscale Anxious-Passive and Emotional Indulgence of Conners Teacher Rating

Scale. The results of Anxious-Passive subscale indicated the therapy to be ineffective and the Emotional Indulgence subscale indicated the SFBT to be mildly effective.

Nelson and Kelley (2001) examined the marital satisfaction and found SFBT to be mildly effective on Revised Dyadic Adjustment Scale (RDAS) but ineffective on Kansas Marital Satisfaction Scale (KMSS).

Naude (1999) also studied marital problems and found SFBT to be moderately effective for Relationship Thermometer Ratings but ineffective for goal attainment.

Polk (1996) studied the effect of SFBT on alcohol drinking behavior and attendance rates at work for adults in an employee assistance program and found 100 % abstinence for day time drinking and increase in attendance at work thus reflecting high effectiveness for alcohol abstinence and mild effectiveness for attendance at work.

Estrada and Beycbach (2007) explored the capableness of SFBT on deaf and depressed individuals. They reported that depression symptoms reduced considerably in 4 to 8 sessions, thereby reflecting moderate success.

In an effort to compare the effectiveness of SFBT and alternate therapies, **Schmit, Schimt, and Lenz** (2016) analyzed 12 studies using SFBT and alternate therapies and concluded that clients receiving SFBT reported almost 24 % fewer symptoms of one standard deviation than those who received other therapeutic treatments. They also concluded that the role of mediating variables played an important role. To this end, they found that the heterogeneity of the sample was responsible for approximately 61 % of the total variability. On the other hand, interest played a negligible role. The further analyses of effect of age group revealed no significant differences of the effect between youth, adolescents and adults.

From the evaluation of 26 studies, **Schmit, Schmit, and Lenz** (2016) found that the decrease in internalizing symptoms in youths and adults were small in comparison to other treatment approach or no treatment. **Bond et al.** (2013) also found that SFBT had a partial effect on internalizing disorders among children. **Corcoran and Pillai** (2009) reviewed the effectiveness of SFBT but did not report

conclusive results. It is suggested in some studies that counselor and mental health professionals should consider the severity of symptoms of internalizing disorders like depression and anxiety (Erford, et al., 2011; Erford, Kress, Giguere, Cieri, & Erford, 2015), for implementing an effective treatment approach based on research offering practical meaningfulness.

The study of the effectiveness of SFBT shows that for depression the SFBT leads to almost 24% improvement in 6-9 sessions which quite progressive when compared to other approaches. In other words, SFBT leads to significant transformations in a short time. The effectiveness of SFBT has been recorded for internalizing disorders (Schmit, Schmit, & Lenz, 2016); for intellectual disabilities (Roeden, Maaskant, & Curfs, 2014); group therapy with adults on problem control (Quick & Gizzo, 2007); with group therapy on students with raised self-regulation (Fitch, Marshall, & McCarthy, 2012). Depth analysis of the effectiveness of SFBT with different age group revealed that it was 5 times better on adults than on youth and adolescents. Further, SFBT produced results two times better results on international domicile clients than on US-domiciled clients. **Kim et al., (2015)** reported the effectiveness of SFBT in reducing internalizing disorders in Chinese clients.

Different studies have studied the outcome of applying Solution focused brief therapy on childhood and teenage problems. **Kim and Franklin (2009)** did a systematic review of the available studies and included seven studies in that. Of the seven studies, only one was experimental and the other six were quasi-experimental. Other positive aspects of the studies were that there were more than one investigator, the treatment manual was used, the standardized measure was used, fidelity evaluation was done and the studies were done in real life situations. The research results showed that SFBT had better engagement adherence and few dropouts as compared to Cognitive behavioral therapy given to 86 students in the age range of 5-17 years with behavioral problems like aggressiveness, conduct problems, and impulsivity. The post-test scores did not show any significant differences as both the groups received the therapy. The results reflect that though there was an enhancement in all the

participants, the group receiving solution focused brief therapy showed better adherence to treatment engagements and there were few dropouts (Corcoran, 2006)

Another study reviewed by **Kim and Franklin** (2009) found the effect of SFBT on internalizing problems among school children. The study was designed to see the effect of group SFBT on the self-esteem of children of prisoners and included 10 elementary school children, 5 in the experimental group and 5 in the control group. The different techniques of SFBT like miracle question, scaling question, exploring the exceptions, etc. were incorporated. The results reflected a statistically significant increase in the self-esteem of the group with SFBT treatment and there was a negligible change in the control group (Springer, Lynch, & Rubin, 2000).

Research designed to see the effectiveness of SFBT on behavioral problems and internalizing outcomes among 67 students found that there was a significant decrease or improvement in both internalizing and externalizing scores on the measure used i.e. Teachers Report Form. The results reported a large effect on the internalizing problems and medium effect on externalizing problems. In contrast, the score of Youth Self-Report did not show much difference in the experimental group that was given SFBT and the control group for the internalizing problems. On the other hand the Youth Self-Report reflected a considerable drop in the externalizing problem scores (Franklin, Moore, & Hopson, 2008).

The research to study the effect of solution-focused brief therapy on academic performance was also carried out. One study was done by **Newsome** (2004) on middle school students with academic and attendance problems. There were in total 52 students, 26 in the experimental group which was given Solution focused brief therapy and 26 in the control group for comparison who did not receive any treatment. The control group was given SFBT once in a week for 8 weeks where the techniques like scaling, miracle question, goals and study work were used. The results indicated a medium effect on grades of the experimental group and no statistical difference for attendance between the SFBT and comparison group.

Franklin & Gerlach (2007) did a study on two groups of high school children to study the effect of SFBT on credits, attendance and graduation rate using a quasi-

experimental design. The aim was to evaluate the effectiveness of SFBT in dropout prevention. The experimental group which was given SFBT had 46 students and the comparison group had 39 students. Both the groups were matched on the at-risk characteristics. The score of the repeated measure ANOVA showed that there was a change in credits attempted by both the groups. The independent sample t-test showed that the experimental group earned significant higher credits than the control group. On the other hand, the comparison group had more improvement in attending classes than the experimental group. **Franklin and Gerlach (2007)** added that the experimental and control group should not be compared for attendance as the experimental group was on a self-paced curriculum where they could stop attending classes once the curriculum was completed thus making it an inaccurate measure for determining the effect of the intervention.

To evaluate the graduation rate, **Franklin & Gerlach (2007)** followed up all the students of experimental and control groups. They found that 90% graduated from the control group while only 81% graduated from the experimental group and the remaining students were still enrolled in different schools.

Froeschle, Smith & Ricard (2007) designed a study using randomized experiment design to examine the effectiveness of SFBT on self-esteem, academic problems and substance abuse. The subjects were adolescent females and the techniques that were used included SFBT group sessions, mentoring and action learning with an aim to reduce the substance use and behavioral issues. The results supported SFBT as statistically significant difference was reported between the two groups on drug use, attitude towards drugs, knowledge of symptoms of drug abuse and behavior scores as reported by parents and teachers.

The defining of small, concrete goals in Solution-focused brief therapy works well in school situations as they have restricted time and assets (Murphy, 1996).

Harris and Franklin (2002; 2008; 2009) designed a Taking Charge (TC) intervention to help adolescent mothers. The aim was to reduce absenteeism and improve grades among adolescent mothers in district high schools. Three studies were designed; one was a randomized clinical trial and the other two were quasi

experimental studies. Results found a significant high grade point average for the experimental group in all three studies. Other indicators of improvement were social problem solving and active coping. These results were found to be true at even 6 weeks follow up.

Solution-focused brief therapy has also been used for alcohol treatment. **Miller, Wilbourne, and Hettema** (2003) reviewed 381 outcome studies of alcohol treatment and found brief therapy models to be quite effective for alcohol problems. It was found that common factors like empathy, hope, and self-efficacy exerted a strong influence on the effect. The principles of SFBT were found to be more influential than the technique. The inclusion of family members and the partners in alcohol treatment and using the family therapy approach of SFBT that includes reducing pessimistic interaction, overcoming the obstacles to change, reframing the thought process and improving behavioral competence had a significant impact in reducing the alcohol problems (Isebaert L. c., 2004; 2007).

Solution-focused brief therapy has also been used on **adolescents in foster care**.

Van Dyk (2004) conducted a study to see the effect of SFBT on the backsliding rate of adolescent offenders in foster care. The results indicated that adolescents' offenses reduced significantly with a lesser return to foster care. This study lacked standardized measures and the absence of a comparison group. **Koob and Love** (2010) reported a significant decrease in disruptions in foster care adolescents' who were given residential treatment using SFBT.

The use of SFBT in mental health care settings reported 77% and 54% improvement in the client's satisfaction or improvement in the problem situation and helped them reach their goals (Burr, 1993; Lee M. Y., 1997).

The collaborative clinical environment and stress on the client's strength rather than on the expertise of the therapist decreases the resistance of adolescents' and motivates them to continue therapy (Bertolino, 2003; Corcoran & Stephenson, 2000; Lethem, 2002)

A study with 112 subjects in the treatment group and 91 in the control group from foster care homes, mental health care center and rehabilitation hospital was conducted to see the effect of SFBT on the perception of a problem, client's behavior and general adjustment. The results concluded that there were significant improvements in the approach towards problems and subjective adjustments of the adolescents from all the groups in an average of three sessions. These results led to the belief that SFBT can meet the requirements of adolescents and can be the first choice of intervention for them (Pakrosnis & Cepukiene, 2012).

Five well controlled studies using SFBT were reported which reflect significant improvement in depression among college students measured on the Beck Depression Inventory (Sundstrom, 1993); significant improvement of parenting skills measured on Parenting Skills Inventory (Zimmerman, Jacobsen, MacIntyre, & Watson, 1996); significant between group differences of the orthopedic rehabilitation patients on Family Crisis Oriented Personal Evaluation Scales and the Psychological Adjustment to Illness Scale Revised (Cockburn, Thomas, & Cockburn, 1997); decrease in the recidivism rates among both the adult Swedish prison population and institutionalized adolescent offenders (Lindforss & Magnusson, 1997; Seagram, 1997).

A study conducted to see the effect of "solution-focused wellness intervention" on the stress level and the wellbeing of college students found that "brief solution-focused wellness intervention" improved the perception about wellness and lead to a decrease in stress among the college students (Beauchemin, 2018)

As research is conducted to test the hypothesis, so to see whether the results support or reject the hypothesis for the present research the following analysis is done:

4.5.1 Hypothesis 1: Solution-focused brief therapy will have a positive impact in reducing the level of anxiety in college students.

At the beginning of this research it was expected that the solution focused brief therapy will have a positive impact on reducing the level of anxiety in college students. It was found that the t-value 7.879 at $df = 29$ is significant as $p < 0.01$ whereas the t-value 1.362 at $df = 29$ is not significant. So, there is a significant difference between the pre and post-test scores with respect to anxiety for the

experimental group and not significant for the control group. The repeated measure ANOVA also led to the conclusion that a significant difference existed between the pre and post test scores of the experimental group. As the value of the t-test is significant at 0.01 levels, so the hypothesis stating that solution-focused brief therapy will have a positive impact on reducing the level of anxiety in college students is accepted. As the results are significant at 0.01 level, so it can be said that if the present research is repeated then there are 99 percent chances of getting similar results.

4.5.2 Hypothesis 2: Solution-focused brief therapy will have a positive impact on reducing the level of depression in college students.

It can be inferred that the value of paired t-test of experimental group pre- and post-therapy on depression comes out to be 13.303 which is significant at 0.01 levels as $p < .01$. These results imply that there is a significant difference in the depression levels of the experimental group before and after the therapy. Further analysis with repeated measures ANOVA, also supports these findings. The $F(1,29) = 54.47, p < .01$ implies that there is a significant difference between the pre-test and post test scores on the depression of the experimental group. So, the hypothesis stating that solution-focused brief therapy will have a positive impact on reducing the level of depression in college students is accepted. As the results are significant at 0.01 level, so if similar research is repeated 100 times then there are 99 chances of getting similar results.

4.5.3 Hypothesis 3: Demographic variables will make a significant difference in anxiety and depression in college students.

At the beginning of the study, it was hypothesized that demographic variables will make a significant difference in anxiety and depression in college students. Independent sample t-test for anxiety and depression on gender difference (refer table 4.13) and F-value of one-way ANOVA done to know the difference made by gender on anxiety and depression (refer the Table 4.14) come out to be insignificant. So, the hypothesis stating that demographic variables will make a significant difference in anxiety and depression in college students is rejected and the null hypothesis stating that there is no difference made by demographic variables on anxiety and depression in college students is accepted.

In the present study, it has been found that the main reasons for anxiety and depression in college students are career consciousness. The students realize that they have the responsibility of the family and have to work to win the bread for the family in the coming time. They feel whether they will be able to get a good job or not. These feelings are a source of anxiety for the students. At the same time, the subjects of the present study also reported conflict with parents. In other words, the subjects felt that their parents are not providing them the support they want. These feelings aggravate their anxiety and lead to depression. They feel that their parents are demanding and do not understand their problems. The reason for the anxiety and depression of some of the students was the inability to pursue the studies in the desired direction. One of the subjects reported her desire to go abroad but the parents were not supporting this decision. The family environment, conflicts between the parents, conflicts between the parents and grandparents were some other reasons for dissatisfaction leading to anxiety and depression. The common indications of anxiety and depression as reported by the participating subjects are memory loss, inability to sleep, lack of interest in daily activities, aggression etc. So, the main factors behind the anxiety and depression of the participating subjects were either family-based or future oriented.

The counselor using the solution focused brief therapy, made them shift their focus from the problems to the solutions. The students were made to visualize their aim with miracle question and motivated to work towards achieving those goals than to remain entangled in the routine problems. The solution-focused brief therapy also helped them in understanding how they can coordinate better with their parents and bring in difference in the family environment leading to the well-being of the whole family. Another aspect that can be attributed to the change brought about by the SFBT is the support received from the counselor. The counselor helps in the ventilation of the emotions leading to an enhanced ability to manage stress. Social support has been found to help in recovering from depression (Keitner, et al., 1995; Sherbourne, Hays, & Wells, 1995). It has been observed in different studies that the language usage and framing of the question is quite vital for the working of SFBT as these correlate with

the process of coconstruction, the helpful relationship and building of the solutions to the problems (Berg & De Jong, 1996; De Jong & Berg, Coconstructing,2001).

The reason for the insignificant effect of demographic variables on the anxiety and depression in college students may be due to the fact that the group selected for the present study was from a similar age and socioeconomic status. Some other studies have also reported no difference in the prevalence of depression among male and female college or university students (Bayram & Bilgel, 2008; Arslan, Ayranci, Unsal, & Arslantas, 2009). Another study found that both males and females show a similar pattern of depression and found no differences in the rates of prevalence of depression among both the genders (Yusoff, et al., 2013; Bostanci, et al., 2005). A study found an insignificant difference between the depression among male and female university students (Haldorsen, Bak, Dissing, & Petersson, 2014).

So, it can be argued that solution focused brief therapy is an effective therapy for both depression and anxiety in college students. It is an evidence-based therapy and quite brief as compared to other popular therapies. A shift of focus from the problems to the solutions is the essence of this therapy. Though not much systematic research is done with solution-focused brief therapy, yet the present research has given a fruitful contribution to this new emerging therapeutic approach.

The present research is a systematically designed research with a clearly defined population sample and control of the other significant variables. All the subjects were given therapy by the same counselor to maintain uniformity. The screening instruments Beck Depression Inventory and Beck Anxiety Inventory were administered as per the procedure. The details of the subjects were noted down carefully. At the termination of the counseling, the feedback from the client was also taken. The clients felt better towards the end of the therapy. They reported as being greatly benefitted by the therapy. Their facial expressions expressed confidence and feelings of happiness.

Hence, in this way, in SFBT the counselor plays the role of an expert who elicits and builds on the client's abilities, experience, and other resources to shift the attention from the problem to solutions. The different questions asked by the counselor aimed

at helping the client take a step forward towards their aims. These objectives were aimed at the very beginning right from the first session in the form of miracle question, exception question etc. (Lipchik, Derks, Lacourt, & Nunnally, 2012). De Shazer believed that change is always taking place and change in one aspect leads to change in multiple other aspects (de Shazer, 1982).

In the end, it can be inferred that solution-focused brief therapy was quite effective in managing anxiety and depression of the college students. The statistical analysis with t-test shows that the pre-therapy and post-therapy depression and anxiety of the control group are almost the same. It can be said that time did not show much effect on the level of anxiety and depression of the control group. As the control group did not receive any intervention and no significant change has been noticed in this group. On the other hand, it can be summed up that there is a significant difference between the depression and anxiety of pre-therapy and a post-therapy score of the experimental group. The only difference between the experimental and control group is the presence of intervention, so it can be said that solution-focused brief therapy brought about a significant change in the depression and anxiety of the experimental group. Therefore, SFBT has been found to be a good therapy for variable problems. SFBT can be called a therapy model which by building the meaning along with the client, bringing forth the strengths of the client, by having a good bond with the client sets attainable goals, arouses hope in client and thus helps the client to reach the solution (Franklin, Zhang, Froerer, & Johnson, 2017).

The solution-focused brief therapy helped the subjects to acquire new insight into their life situation and motivated them to look for solutions than to be preoccupied with problems. As this therapy is quite similar to the cognitive set up of the Indian philosophy, for example, the Buddhist idea that “change is a constant, inevitable and continual process.” (Ratner, George, & Iverson, 2012). So, more research can help in making available an effective brief therapy conducive to the Indian system of thought.

Chapter 5

Conclusion

5.1 Strengths of The Study

The following are the strengths of this study:

- The inclusion and exclusion criteria are strictly followed
- The subjects are assigned randomly to the experimental and control group.
- The intervention was given by the trained therapist.
- The subjects were given positive regard
- The rights of the subjects were respected
- The information of the clients is kept confidential
- The statistics analysis was done with care
- Equal representation was given to both the genders
- No discrimination on the basis of color, caste or creed was done.

5.2 Delimitations of the study

The aim of the present research is to study the effectiveness of Solution-focused brief therapy on anxiety and depression in college students. The main limitation of the study is the limited sample. In this research, the solution-focused brief therapy intervention was given to 30 males and females only. So, more studies should be done to see the effect of solution focused brief therapy in college students.

Another limitation of the present research is that it studies only depression and anxiety. Solution-focused brief therapy can be good therapy for many other psychological problems that were not a part of the present study. So, more research should be carried out on the varied problems of college students.

The present research used the solution-focused brief therapy as a counseling tool and not on the clinical sample. The participants in the present study had mild to moderate depression or anxiety.

5.3 Further Research

The therapeutic intervention with solution focused brief therapy has been found to be quite effective in this research. But as elaborated above, there are some limitations to this study. The major limitation is the limited sample. So, more research with a wider sample should be done before generalizing to the large population.

Another limitation of this study is that the effectiveness of solution-focused brief therapy was studied only for anxiety and depression. As this has proved to be an effective therapy for these problems, it could be good therapy for other problems also. So, further research should be carried out to test the effectiveness of solution-focused brief therapy on other problems.

The effectiveness of the solution-focused brief therapy on the clinical population should also be studied so that a greater number of people may get its benefit.

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