



Impact of Solution-Focused Brief Therapy on Depression and Intolerance of Uncertainty of Female Adolescents with Academic Failure

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Quantitative Study

Abstract

Background: This study explores the potential of Solution-Focused Brief Therapy (SFBT) as an intervention strategy for female adolescents facing academic failure. Despite its effectiveness, the specific efficacy of SFBT in mitigating depression and intolerance of uncertainty (IU) in this demographic is relatively unexplored. The research aims to provide insights into evidence-based interventions tailored to the unique needs of adolescent girls, fostering resilience, and promoting well-being in this vulnerable population. The study investigated the impact of SFBT on depression and IU in female adolescents with academic failure.

Methods: The experimental group comprised 15 participants, while the waitlist control group also consisted of 15 subjects. Data were collected using the Intolerance of Uncertainty Scale-12 items (IUS-12) and Beck Depression Inventory (BDI) at three phases: pretest, posttest, and follow-up. An analysis was conducted using a mixed analysis of variance (ANOVA) to examine the effects of treatment over time.

Results: A significant difference was revealed between the experimental and control groups concerning depression and IU. Specifically, participants in the experimental group exhibited reduced levels of depression and IU compared to the control group. Furthermore, the follow-up assessment indicated stability in the improvements observed in the experimental group ($P < 0.001$).

Conclusion: These findings underscore the efficacy of SFBT in alleviating depression and IU in female adolescents facing academic challenges. The study contributes to the understanding of therapeutic interventions for adolescents experiencing academic failure and highlights the importance of addressing mental health concerns in this population through targeted interventions like SFBT.

Keywords: Solution-focused brief therapy; Depression; Intolerance of uncertainty; Adolescents

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Introduction

Intolerance of uncertainty (IU) in adolescents refers to their inability to tolerate ambiguous or uncertain situations, which can exacerbate anxiety and distress. Research has shown that IU is associated with anxiety, depression, and obsessive-compulsive tendencies among adolescents (Gu, Gu, Lei, & Li, 2020; Wheaton & Ward, 2020). IU can manifest as both future-oriented anxiety (worrying about the future) and inhibitory anxiety (avoiding uncertainty). High levels of IU are associated with an increased risk of depressive symptoms in adolescents (Bottesi, Iannattone, Carraro, & Lauriola, 2023). The prevalence of IU among adolescents has been the focus of several studies, highlighting its significance in understanding and addressing mental health issues in this age group. The concept of IU in adolescents is highly noteworthy, emphasizing its relevance and importance in mental health research and interventions for this demographic (Andrews et al., 2023; Cuesta-Zamora, Ricarte, Ros, Latorre, & Plateau, 2023; Şimşek, 2023). Understanding and addressing the IU in adolescents is crucial for developing effective prevention and intervention strategies aimed at addressing mental health issues in this population.

IU in adolescents refers to an inability to tolerate ambiguous or uncertain situations, which can lead to increased anxiety and distress (Ye et al., 2023). Adolescents with IU may experience cognitive, behavioral, and emotional responses to ambiguous situations. They may also exhibit obsessive-compulsive tendencies towards exercise, which can be a risk factor for anxiety and eating disorders (Cuesta-Zamora et al., 2023).

The causes of anxiety and depression in adolescents with an IU are not explicitly mentioned in the search results. However, some factors that may contribute to the development of anxiety and depression in this population include:

- 1) IU: Adolescents with IU may be more sensitive to ambiguous or uncertain situations, leading to increased anxiety and distress (Boelen, rinssen, & van Tulder, 2010),
- 2) Negative emotions: The IU is associated with negative emotions, predisposing individuals to experience negative feelings (Boelen et al., 2010),
- 3) Sociodemographic variables: Some studies have found associations between sociodemographic variables such as gender and age and the IU in adolescents (Ye et al., 2023),
- 4) Autism spectrum disorder (ASD): IU is associated with anxiety and depression in adolescents with ASD (Cai, Richdale, Dissanayake, & Uljarević, 2018),
- 5) Emotion regulation: Adolescents with an IU may have difficulty regulating emotions, which can contribute to the development of anxiety and depression (Boulter, Freeston, South, & Rodgers, 2014).

Solution-Focused Brief Therapy (SFBT) is a short-term, goal-focused, and evidence-based therapeutic approach that emphasizes setting clear, concise, and realistic goals, and working out how to achieve them. It is future-focused, goal-directed, and focuses on solutions rather than on the problems that brought clients to seek therapy. SFBT is characterized by its emphasis on discussing solutions rather than problems, and it promotes positive change by encouraging individuals to focus on what they want and their strengths, rather than what they cannot do. The therapy typically involves between five and eight sessions, and it can be helpful for a variety of issues including anxiety, depression, self-esteem, relationship issues, and coping with changes in life. SFBT is intended to help clients be attentive to the positive things in their lives, and it allows individuals to find solutions and get results quickly, without requiring a deep dive into their past. The therapist uses

specific questioning techniques, 0-10 scales, empathic support, and compliments to help the person. SFBT has been shown to be effective in treating depression, anxiety, behavioral problems, parenting, and psychosocial and interpersonal problems, with numerous randomized clinical control studies and meta-analyses demonstrating its positive benefit (Ratner, George, & Iveson, 2014). In a meta-analysis, researchers have shown that short-term solution-focused therapy is effective in treating depression, anxiety, behavioral problems, parenting, and social and interpersonal issues. Multiple randomized controlled trials (RCTs) and meta-analyses have demonstrated its positive benefits (Karababa, 2023).

Short-term solution-focused therapy has demonstrated efficacy in addressing various psychological problems across different populations, including adolescents (Franklin et al., 2023a; Hsu, Eads, Lee, & Wen, 2021; Zhang, 2022). While direct research on the effectiveness of short-term solution-focused therapy in addressing IU in adolescents is limited, there is evidence of its effectiveness in improving self-efficacy and reducing psychological distress, which is associated with IU. For example, a study on the effectiveness of short-term solution-focused therapy in increasing self-efficacy in individuals with physical disabilities showed positive results (Putri, Razzaq, & Rasmanah, 2023).

Thus, there is a need to investigate SFBT's potential in reducing teenage IU and depression given the substantial negative effects of IU and depression on adolescent mental health and the efficacy of SFBT in treating a variety of psychological issues. There is, however, a dearth of actual studies on how well SFBT works in treating this population's IU and depression. Thus, the purpose of this research is to ascertain how adolescents' depression and IU are affected by SFBT. Teens who receive SFBT are expected to significantly lower their levels of depression and IU in comparison to those who do not receive this kind of intervention.

Methods

Study Design and participants: The current study employed a quasi-experimental approach, including a control group, pretest, posttest, and 3-month follow-up design. All female students registered in the high schools in the city of Neyshabur, Iran, for the academic year 2022-2023, made up the research population. A convenience sample of thirty students was selected from this population. The experimental group and the control group consisted of fifteen participants. While the control group was placed on a waiting list, the experimental group underwent SFBT intervention. Female gender, having depression, lack of suicidal ideation, and absence of severe mental and personality disorders (based on interview in the screening session) were among the inclusion criteria. Refusing to participate in the research and missing more than two therapy sessions were also grounds for exclusion.

Sample size: We used G*Power software to calculate the sample size based on an effect size of 0.35 (based on previous studies), number of groups (2), using repeated measures analysis of variance (ANOVA), within-between interaction, alpha of 0.05, power of 0.95, number of measurements (2), expected correlation among repeated measures (0.5), and nonsphericity correction E (1). The total sample size was determined to be 30 subjects.

Instruments

Intolerance of Uncertainty Scale (IUS): This scale is a psychological assessment tool developed by Carleton et al. (2007) to measure individuals' tendency to find uncertainty unacceptable, stressful, and distressing. This questionnaire consists of 12 items, and

respondents rate each item on a 5-point Likert scale from one (never) to five (completely true). The scale demonstrates good internal consistency, with Cronbach's alpha coefficients typically ranging from 0.80 to 0.90 across different samples, indicating high reliability in measuring the intended construct. The scale has shown good convergent validity, exhibiting significant correlations with related constructs such as anxiety, worry, and psychological distress. Additionally, the scale demonstrates discriminant validity by showing weaker correlations with unrelated constructs, indicating divergent validity (Carleton, Norton, & Asmundson, 2007). Psychometric validation of the questionnaire was conducted by Rashtbari et al. (2022) in Iran, yielding a Cronbach's alpha coefficient of 0.89 for internal consistency. Convergent validity of the questionnaire was also reported with anxiety and depression scales. In this study, the reliability of the questionnaire was calculated as 0.79.

The Beck Depression Inventory-II (BDI-II): This scale is a self-assessment questionnaire introduced by Beck et al. (1961) to measure the severity of depressive symptoms. It consists of a 21-item self-report questionnaire, with each item (symptom of illness) divided into four degrees of severity, ranging from zero to three. A score of zero indicates the lowest level of severity, while a score of three indicates the highest level of severity for experiencing a symptom of depression. The questionnaire is used to assess the severity of depression in individuals aged 13 and older. The reliability of this questionnaire has been reported with internal consistency using a Cronbach's alpha coefficient of 0.86. Additionally, the reliability of this questionnaire was calculated using the split-half method with a Spearman-Brown coefficient of 0.93. The scale has also demonstrated high concurrent validity, indicating its good correlation with other depression measures and related constructs, such as physician-conducted interviews and other self-report depression measures. Furthermore, it has good discriminant validity and can distinguish significantly between individuals with and without depression (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). In Iran, Stefan-Dabson et al. (2007) estimated the reliability of this scale with internal consistency using a Cronbach's alpha coefficient of 0.91. For the validity of the questionnaire, they utilized exploratory factor analysis (EFA) to assess structural validity, which revealed three extractable factors explaining 37.44%, 43.64%, and 49.23% of the total variance, respectively. They named these three factors somatic-vital, cognitive-psychological, and pessimism-worthlessness. In the present study, the reliability of this scale was demonstrated with a coefficient of 0.85, calculated using the internal consistency of the questions with Cronbach's alpha coefficient.

Procedure: First, the participants were assigned to experimental and control groups. Fifteen participants were placed in the experimental group, and another fifteen were placed in the control group. Group therapy was conducted. Before the therapy sessions, the participants completed the questionnaires as pretests. After completing the therapy sessions, the questionnaires were administered again as posttests to the participants. The intervention program of SFBT was conducted in six two-hour sessions, held weekly by the first author. The content of the therapy sessions is reported in table 1.

Analysis: A mixed-design ANOVA using SPSS software (version 27, IBM Corporation, Armonk, NY, USA) has been used to look at the effects of treatment (experimental vs. control) and time (pretest, posttest, follow-up) on depression and IU at the same time. We used this test to evaluate both between-subjects (group) and within-subjects (repeated measures) effects.

Table 1. The summary of Solution-Focused Brief Therapy (SFBT) sessions

Session	Goal	Content
1	Establishing rapport and setting goals	Introducing and explaining the purpose of the meetings, establishing rapport by creating a supportive and non-judgmental environment, assessing clients' presenting issues, including symptoms of depression and intolerance of uncertainty Collaboratively setting goals for therapy, focusing on specific areas such as improving mood, reducing anxiety, and enhancing academic performance,
2	Identifying exceptions and resources	exploring exceptions to clients' depressive symptoms and moments when they have felt less uncertain about their academic abilities, identifying internal and external resources that clients can draw upon during challenging times, using scaling questions to assess clients' current level of depression and uncertainty, and to gauge progress over time
3	Amplifying strengths and coping strategies	Amplifying clients' strengths and coping strategies that have helped them navigate through difficulties in the past, utilizing solution-focused techniques such as the miracle question to envision a future where their depression and uncertainty have significantly decreased, encouraging clients to identify small, achievable steps they can take to move closer to their desired outcomes
4	Building hope and reframing perspectives	Reinforcing hope by highlighting any progress or positive changes observed since the start of therapy, challenging negative beliefs and cognitive distortions related to academic failure, depression, and uncertainty, encouraging clients to reframe their perspectives on setbacks and failures as opportunities for growth and learning
5	Consolidating progress and addressing barriers	Reviewing clients' progress towards their goals and celebrating any achievements, no matter how small, addressing any barriers or obstacles that may be hindering further progress, collaborating with clients to develop strategies for overcoming these barriers and maintaining positive changes beyond therapy
6	Review and relapse prevention	Reflecting on clients' overall experience with therapy and discussing any remaining concerns or unresolved issues, developing a relapse prevention plan by identifying early warning signs of depression and uncertainty, as well as coping strategies to manage them, discussing options for ongoing support or follow-up, such as booster sessions or referrals to other resources if needed Throughout each session, the therapist should maintain a solution-focused approach by emphasizing the client's strengths, resources, and potential for change. Sessions should also be flexible and tailored to the individual needs and preferences of clients.

Ethics implications: Several ethical guidelines were followed in the investigation of SFBT's effects on female teenagers who had failed their scholastic courses which included getting the participants' and their legal guardians' informed consent, protecting privacy and confidentiality, reducing the possibility of harm or distress, abiding by ethical standards for fair treatment and equitable representation, and upholding integrity and transparency in every facet of the study. Participants were made aware of their freedom to leave the study at any moment and without facing any repercussions. Additionally, the research team adhered to the ethical conduct of the study and the preservation of participants' rights and well-being by upholding the values of beneficence, respect for autonomy, fairness, and integrity.

Results

The participants' average age of experimental group was roughly 16.33 [standard deviation (SD) = 1.45] years. The sample's mean academic performance score was approximately 14.53 (SD = 0.07), indicating a moderate degree of academic

achievement. According to the participants' grade level breakdown, 26.7% were in the tenth grade, 53.3% were in the eleventh grade, and 20.0% were in the twelfth grade. Based on the statistics, it appears that the majority of participants in the sample were eleventh-grade students, making up over half of the total. According to the information gathered from the participants of control group, each of the 15 subjects gave accurate answers regarding their age, grade level, and academic performance. There were no missing values found for any of the variables. The participants' mean age was roughly 16.33 years (SD = 1.42), indicating that there was not much variation in the sample's age. The mean academic performance score was 14.67 (SD = 1.17), indicating moderate variability in these demographic characteristics. The grade level distribution of the participants shows that 40.0% were in the 11th grade, 26.7% were in the 12th grade, and 33.3% were in the 10th grade. This implies that the sample contains a well-balanced mix of students from various grade levels.

Descriptive statistics, such as the means and SDs for the scores for IU and depression (Table 2) were calculated for the analysis. To further investigate the effect of the therapeutic intervention on these variables, a mixed ANOVA was performed (Table 3).

The means and SDs for depression and IU across various measurement points and treatment groups are shown by these statistics. Before proceeding with the mixed-ANOVA analysis, it is essential to examine the assumptions of the test. The main assumptions of mixed-ANOVA include:

Normality: The results of Shapiro-Wilk test showed that the distributions of depression and IU were normal.

Homogeneity of variances: Levene's test results showed that the variances of the dependent variables (depression and IU) were equal across groups and time points.

Sphericity: The results of Mauchly's test of sphericity showed that the equality of variances of the differences between all possible pairs of within-subjects conditions (i.e., time points) violated. Therefore, corrections such as the Greenhouse-Geisser or Huynh-Feldt adjustments were needed. In this study, the Greenhouse-Geisser correction was used.

These results imply that the sphericity assumption was broken even though the data satisfied the requirements of normality and homogeneity of variances. To solve this problem, the Greenhouse-Geisser adjustment was used. These procedures confirm the accuracy and reliability of findings of the mixed-ANOVA analysis, which are mentioned in table 3.

There were significant main effects for time [$F_{(1,51)} = 717.15, P < 0.001$] and the interaction between time and group [$F_{(1,51)} = 627.50, P < 0.001$], indicating that both time and group had a significant impact on IU scores. The effect sizes for these effects were large ($\eta^2 = 0.96$ and 0.95 , respectively). Additionally, there was a significant main effect for group [$F_{(1)} = 12.94, P = 0.001$], suggesting differences in IU scores between the control and experiment groups.

Table 2. Descriptive statistics

Variables	Group	Mean ± SD		
		Pretest	Posttest	Follow-up
Intolerance of uncertainty	Control	23.40 ± 2.58	23.20 ± 3.56	23.80 ± 4.63
	Experiment	24.80 ± 3.14	16.40 ± 3.62	16.06 ± 3.43
	Total	24.10 ± 2.91	19.80 ± 4.94	19.93 ± 5.61
Depression	Control	44.80 ± 6.97	43.33 ± 7.26	43.26 ± 7.34
	Experiment	45.33 ± 7.04	34.33 ± 6.36	34.66 ± 6.16
	Total	45.06 ± 6.89	38.83 ± 8.12	38.96 ± 7.96

SD: Standard deviation

Table 3. Mixed analysis of variance (ANOVA) test results

Variables		df	MS	F	P-value	Effect size
Intolerance of uncertainty	Time	1.51	351.00	717.15	< 0.001	0.96
	Time*group	1.51	307.13	627.50	< 0.001	0.95
	Error	42.31	0.48			
Depression	Group	1.00	431.21	12.94	0.001	0.32
	Time	1.08	704.81	64.61	< 0.001	0.69
	Time*group	1.08	404.04	37.04	< 0.001	0.57
	Error	30.22	10.90			
	Group	1	728.17	5.60	0.025	0.16

df: Degree of freedom; MS: Mean squares

Similar to IU, there were significant main effects for time [$F_{(1,08)} = 64.61, P < 0.001$] and the interaction between time and group [$F_{(1,08)} = 37.04, P < 0.001$] for depression scores. The effect sizes for these effects were moderate to large ($\eta^2 = 0.69$ and 0.57 , respectively). However, the main effect for group was marginally significant [$F_{(1)} = 5.603, P = 0.025$], indicating potential differences in depression scores between the control and experiment groups.

The results showed that 96% of the variability in IU was explained by time, 95% by time*group interaction, 32% by group differences, and 69% by time*group interaction in depression. The interaction between time and group also significantly differed between the groups, with 57% of the variability in depression due to time*group interaction. The medium effect size of 16.7% in depression was explained by group differences.

To perform pairwise comparisons, the Bonferroni post-hoc test was used, which is a common approach to examine specific differences between pairs of groups or time points while adjusting for multiple comparisons (Table 4).

For the IU variable, significant mean differences were observed between time 1 (pretest) and time 2 (posttest) (mean difference = 4.30, $P < 0.001$), and time 1 (pretest) and time 3 (follow-up) (mean difference = 4.16, $P < 0.001$). No significant difference was found between time 2 (posttest) and time 3 (follow-up) (mean difference = -0.13, $P > 0.999$).

For the depression variable, significant mean differences were found between time 1 (pretest) and time 2 (posttest) (mean difference = 6.23, $P < 0.001$) and time 1 (pretest) and time 3 (follow-up) (mean difference = 6.10, $P < 0.001$). No significant difference was observed between time 2 (posttest) and time 3 (follow-up) (mean difference = -0.13, $P > 0.999$). These results indicate significant changes in both IU and depression scores across different time points, with the most substantial changes occurring between the pretest and posttest, as well as between the pretest and follow-up.

The results imply that depression scores and IU are significantly impacted by SFBT intervention. These findings highlight how crucial SFBT intervention is in affecting participants' psychological outcomes. The effect of time revealed that the SFBT showed a constant impact on participants who received the intervention.

Table 4. Pairwise comparisons

Variables	Time (I)	Time (J)	Mean difference (I-J)	SE	P-value
Intolerance of uncertainty	1	2	4.30	0.34	< 0.001
		3	4.16	0.48	< 0.001
	2	3	-0.13	0.31	> 0.999
Depression	1	2	6.23	0.74	< 0.001
		3	6.10	0.77	< 0.001
	2	3	-0.13	0.17	> 0.999

SE: Standard error

Discussion

The purpose of the study was to find out how SFBT affected the depression and IU of female adolescents who had failed academically. The results of this study shed important light on how well SFBT works for female teenagers who are failing academically in terms of easing depression and decreasing IU. In order to fully comprehend the effectiveness of SFBT in treating depression and IU in teenagers confronting scholastic obstacles, it is helpful to compare the findings of the current study with those of other studies.

The previous studies encompass a range of studies exploring the application and effectiveness of SFBT across various psychological concerns and populations. In order to investigate the possibility of SFBT in treating depression in adolescents and young adults with cancer diagnoses, Zhang (2022) carried out an open pilot study. The study focuses on young adults and adolescents with cancer diagnoses, a demographic that faces particular psychological difficulties, such as depression. Overall, the findings of Zhang's pilot trial point to the possibility and potential efficacy of SFBT as a treatment for depression in young adults and adolescents with cancer. Piryaei et al. (2021) investigated the effect of SFBT on students' body image concerns and social anxiety. Their study suggested that SFBT could be effective in addressing these psychological issues among students. Chen et al. (2023) explored the application of SFBT in treating adolescent depression. Their findings indicated the potential of SFBT as a brief and solution-focused intervention for reducing depressive symptoms in adolescents. Franklin et al. (2023b) conducted a review of the literature on SFBT for substance use. They found evidence supporting the efficacy of SFBT in promoting positive outcomes among individuals struggling with substance abuse. Gupta and Fakhr (2022) examined the use of SFBT specifically in the context of depression. Their research suggested that SFBT could be an effective therapeutic approach for alleviating depressive symptoms. Liaqat and Saleem (2021) presented a single case study demonstrating the application of SFBT for major depressive disorder (MDD). Their study provided support for the effectiveness of SFBT as an intervention for depressive symptoms. A meta-analysis by Hsu et al. (2021) supports the effectiveness of SFBT in addressing behavior problems among children and adolescents, highlighting the positive outcomes of SFBT interventions based on numerous trials.

All things considered, this research adds to the increasing amount of data demonstrating the efficacy and adaptability of SFBT for a variety of demographic and psychiatric issues.

Moreover, the stability of improvements observed in the experimental group at the follow-up assessment is consistent with findings from longitudinal studies examining the long-term effects of SFBT. For instance, Cortes et al. (2016) study focused on identifying factors associated with positive outcomes in SFBT. This follow-up study aimed to investigate the characteristics or processes within therapy sessions that contributed to successful outcomes. By analyzing data from participants who had undergone SFBT, the researchers sought to gain insights into the factors that facilitate positive changes and improvements in clients' well-being. Similarly, the maintenance of gains in depression and IU observed in the current study suggests that the benefits of SFBT may endure beyond the immediate intervention period.

In summary, comparing the results of the current study with existing research underscores the robustness of SFBT as an intervention for reducing depression and

IU among adolescents facing academic failure. By aligning with previous findings and contributing to the growing evidence base supporting the efficacy of SFBT across diverse populations and psychological constructs, this study highlights the potential of SFBT to enhance mental health outcomes and promote resilience among adolescents experiencing psychological distress.

Suggestion: A number of limitations have been noted in the research on SFBT for female adolescents who are experiencing academic failure. These include rigorous study design, comparative studies, family participation, sample size and generalizability, and a solution-building methodology. Future research should concentrate on larger sample sizes, investigate the efficacy of SFBT in various demographic groups, employ rigorous research designs, compare SFBT with other therapeutic interventions, investigate the long-term effects of SFBT, and investigate the role of family involvement in SFBT in order to improve the applicability of SFBT. By doing this, the discipline of solution-focused treatment will progress and evidence-based interventions for a range of mental health issues will be developed.

Limitations: The study on SFBT for female adolescents facing academic failure has several limitations. The sample size of 15 participants may limit generalizability, and the research design may introduce biases. Methodological constraints, such as access to information or cultural biases, could have influenced the results. The study's focus on female adolescents may limit its generalizability to other demographic groups or settings. Acknowledging these limitations is crucial for a comprehensive understanding of research outcomes and enhancing the applicability of interventions promoting mental well-being in vulnerable populations.

Conclusion

SFBT's goal-oriented and solution-focused methodology, which enables people to recognize and pursue attainable goals, is one of its main advantages. Through an emphasis on finding solutions rather than lingering on issues, SFBT helps teenagers create coping mechanisms and strengthen their resilience when faced with obstacles in the classroom. This is consistent with earlier studies showing how successful SFBT is at fostering beneficial outcomes in a range of populations, including teenagers.

Moreover, the stability noted in the experimental group's improvements at the follow-up evaluation emphasizes the long-lasting effects of SFBT on mental health outcomes. This shows that SFBT has long-lasting advantages that improve the general wellbeing of female adolescents who struggle academically even after the initial intervention phase.

The study's conclusions have important ramifications for those working in the mental health field, as well as for educators and legislators who promote the mental health of adolescents. The study emphasizes the value of incorporating evidence-based therapeutic approaches into school-based interventions and mental health support services by highlighting the efficacy of SFBT as a targeted intervention for addressing depression and IU in this population. This emphasizes the value of early intervention and focused assistance for teenagers who are having difficulties in school, ultimately fostering resilience and overall wellbeing in this susceptible group.

All things considered, this study adds to the expanding corpus of research on therapeutic interventions for teenagers experiencing academic failure, highlighting the significance of addressing mental health issues in the context of education. Future studies might examine the long-term impacts of SFBT and look at other variables that might affect how well this demographic responds to treatment, which would contribute

to our knowledge of the best practices for adolescents' mental health therapies.

Conflict of Interests

Authors have no conflict of interests.

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