Potential Clients' View of Language in Therapy

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(ABSTRACT)

This study compares the counselor credibility of therapists who use problem-focused with those who use solution-focused language. Participants from two undergraduate classes at a southeastern state university were assigned to one of two eight-minute videotapes of a role-played family therapy session: problem-focused or solution-focused. This study is a posttest only quasi-experimental design.

One group (N=35) viewed a videotape of a session that used solution-focused language. Another group (N=38) viewed a videotape of a session that used problem-focused language. The same therapist conducted both sessions and the same actors were used as the client couple. After viewing the videotape, participants rated the therapist's credibility (as measured by the Counselor Rating Form – Short Version), completed a Demographic Questionnaire and answered three open-ended questions.

Two research questions were examined in this study: (1) Do potential clients perceive a therapist using solution-focused language as more attractive, experienced, trustworthy, and more credible than the same therapist using problem-focused language? (2) What other variables affect potential clients' view of the therapist?

No significant differences in counselor credibility were found between the two groups. Three categories were discovered in the analysis of the open-ended questions: therapist characteristics, actions/skills of therapist, and other. When asked what they liked the most about the therapist, the majority of the participants' (86 percent) responses fell into the category of actions and skills of the therapist. When asked what they liked the least about the therapist, the majority of the participants' (64 percent) responses fell into the category of therapist characteristics.

DEDICATION

I would like to dedicate this to my parents. Thank you for all your love and support these past few years as I have begun to start my career as a therapist. You remind me every day what I am capable of and what wonderful things I can do in life!

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CHAPTER ONE: INTRODUCTION

"Past research in counseling has focused on the relationship between the counselor attributes that contribute to perceived counselor credibility and attitude or behavior change" (Atkinson & Carskaddon, 1975). Language, as an attribute, is one of the most powerful tools in the therapeutic environment. What a therapist says and how he/she relays the message influence the client's view of the therapist. Anderson and Goolishian (1988) consider the therapist a master conversational artist who is creating and maintaining the therapeutic conversation. Since the therapist may be considered the primary creator of the dialogue, one can assume that therapist credibility is affected by the type of language used in treatment. This study compares the perceived counselor credibility of therapists who use problem-focused and those who use and solution-focused language.

Statement of the Problem

Counselor credibility has been defined as "the client's belief that the counselor possesses information which allows the client to obtain valid conclusions about and deal effectively with his problems" (Strong & Dixon, 1971, p. 562). For the purpose of this study, Atkinson and Carskaddon's (1975) definition of counselor credibility will be used. They define counselor credibility as "an expectation by the client or potential client that the counselor possesses the knowledge of psychology, therapeutic skills, comprehension of the client's problem, and willingness to help the client that is needed for the client to deal effectively with his problems" (Atkinson & Carskaddon, 1975, p. 181).

Language is one of the factors that contributes to the credibility of the therapist. However, many marriage and family therapy models focus specifically on how language is manipulated. The models describe certain techniques and interventions that are based on how the therapist delivers messages to clients.

A shift in marriage and family therapy occurred recently with the introduction of solution-focused therapy. In contrast to the problem-focused theories where the focus is on the past and how problems have been maintained, solution-focused theory focuses on the present and the future and how problems can be solved. This represents a move "away from explanations,

problems, and pathology, and towards solutions, competence, and capabilities" (O'Hanlon & Weiner-Davis, 1989, p. 6).

For the purpose of this study, problem-focused theories are defined as those models of therapy that attempt to obtain a clear picture of what has not worked, repair problem sequences, and search for new ways to solve problems. Included in the category of problem-focused theories are the Structural, Strategic, and Mental Research Institute models of therapy. This study focuses on one problem-focused model, the Mental Research Institute (MRI).

The overall goal of problem-focused theories is problem resolution. Brief therapy, as described by the MRI model, has also been referred to as "problem solving therapy" because of its focus on problem resolution (Molnar & de Shazer, 1987; de Shazer, 1982; Haley, 1977; Watzlawick, Weakland, & Fisch, 1974). This *problem-focused* model concentrates on finding an explanation for why problems exist. Problems develop when life difficulties are mishandled. Problems are maintained by unsuccessful attempts to solve them or by the function they serve in the client's life (O'Hanlon & Weiner-Davis, 1989). According to the Structural model, the goal of treatment is to "free the family symptom bearer of symptoms, to reduce conflict and stress for the whole family, and to learn new ways of coping" (Minuchin & Fishman, 1981, p. 29).

In contrast, the solution-focused model of therapy focuses on client strengths, abilities, and competencies. The therapist using this model is searching for the *exception* to the problem and aims to discover times when the client was able to solve the problem. This evolution of therapy has moved from a "here and now orientation to a future orientation that is unconcerned with how problems arose or even how they are maintained, but instead is concerned with how they will be solved" (O'Hanlon & Weiner-Davis, 1989, p. 12). The therapist's task is to shift the conversation away from how things have stayed the same to how things have changed.

How language is used in these models flows from each model's overall focus. In problem-focused models, interventions and techniques revolve around problem cycles and how they are maintained. In other words, client/therapist conversations deal primarily with how and why the problem is maintained and what the client could do differently to change. It emphasizes that the clients should try something different and do less of what has not worked in the past. Through interventions and homework assignments, the therapist looks to interrupt the dysfunctional behavioral patterns. Some examples of interventions used include: directives, paradoxical interventions, reframing, and circular questioning (Nichols & Schwartz, 1998).

In contrast, the solution-focused model focuses on exceptions to the problem. The therapist/client conversation focuses on the future without the problem and on when the problem did not exist. It emphasizes that the client should keep doing more of what has worked in the past. Through certain interventions, the therapist looks for the capabilities and strengths of the client. Some examples of solution-focused interventions include: complimenting, formula first-session task, miracle questions, and scaling questions (O'Hanlon & Weiner-Davis, 1989).

The role of the therapist in these two approaches to family therapy also differs. In problem-focused models, the therapist takes a directive role; that is, he/she is the expert and is an external force. He/she assists the client in giving up the attempted solutions that have failed and encourages the client to do something different. In the solution-focused model, the therapist takes a collaborative role. He/she works with the client to search for the exceptions, possible solutions, and resources by becoming a part of the client system internally (Nichols & Schwartz, 1998).

Minimal research is available on how potential clients view counselor credibility in relation to the language or focus utilized in therapy. The beginning phases of treatment set the stage for therapy. Therefore, this research aims to examine how potential clients view the focus that is established at the start of treatment. This study does not intend to compare the models, but aims to look at how language is used in the beginning phases of treatment.

Rationale

A recent trend in marriage and family therapy has been a shift from examining the differences between models to looking for the similarities *across* models. Using the work of Lambert and Bergin (1994), for instance, Miller, Duncan, and Hubble (1997) propose four common factors that operate across all therapy models. These factors are: (1) extratherapeutic factors; (2) therapy relationship factors; (3) model and technique factors; and (4) expectancy, hope, and placebo factors. Hope and expectancy factors and relationship factors are especially important for this study.

According to Miller, Duncan, and Hubble (1997), hope and expectancy factors contribute 15 percent to treatment outcome. An emphasis on possibilities and a belief that therapy can work might establish hope and a positive expectation for improvement. Through the acknowledgment of the client's present difficulties and the possibilities for an improved future, a

hopeful atmosphere can be created. Treatment is more productive when the therapist and client "focus on and enhance the factors responsible for change-in-general rather than on identifying and then changing the factors a theory suggest are responsible for causing problems-in-particular" (Miller, Duncan, & Hubble, 1997, p. 127).

Miller, Duncan, and Hubble (1997) propose that relationship factors contribute 30 percent to the outcome of therapy. One of the guidelines for creating a solid therapeutic relationship is that "treatment should accommodate the client's goals of therapy" (Miller, Duncan, & Hubble, 1997, p. 104). Strong therapeutic relationships are formed when the therapist assumes that all clients can make a more satisfying life for themselves, attempts to understand the client's experience, and shares that understanding with the client.

Miller, Duncan, and Hubble's (1997) definitions of hope and relationship incorporate ideas similar to Atkinson and Carskaddon's (1975) definition of counselor credibility. Counselor credibility, as defined by Atkinson and Carskaddon (1975), focuses on how the client perceives the counselor's knowledge of his/her field, his/her therapeutic skills, an understanding of the client's problem, and a willingness to help the client. Miller, Duncan, and Hubble (1997) suggest that strong therapeutic relationships are formed when clients perceive the therapist as warm, trustworthy, nonjudgmental, and empathetic. Hope is created by acknowledging client difficulties and remaining open to the possibilities for a better future. Counselor credibility, therefore, encompasses both the factors of hope and the therapeutic relationship.

Research is lacking on how potential clients view counselor credibility in relation to the type of language utilized in therapy. This study fills this gap by providing information on how potential clients rate the level of counselor credibility of a therapist who uses problem-focused and solution-focused language. This study also examines the differences on the level of counselor credibility between problem-focused and solution-focused language.

Theoretical Framework

The common factors model proposed by Miller, Duncan, and Hubble (1997) provides the general foundation for this research. The researcher has concentrated on two of the common factors: hope and relationship and how they are influenced by the language the therapist uses. Since these factors resemble the researcher's definition of counselor credibility, they provide the background for what is being studied and how it is affected by the use of language.

Four common elements have been identified by researcher Michael Lambert (1992) as cutting across all models of psychotherapy. They include: (1) extratherapeutic factors; (2) therapy relationship factors; (3) model and technique factors; and (4) expectancy, hope, and placebo factors. In their book, Miller, Duncan, and Hubble (1997) discuss how concentrating on the common elements is more important than any specific technique or model since the factors account for most of the change that clients experience in therapy .

Miller, Duncan, and Hubble (1997) propose that extratherapeutic factors contribute 40 percent to the outcome of therapy. The determination of whether any treatment will work depends on the quality of the clients' participation, the clients' perception of the therapist and what he/she is doing. Improvement in therapy relates to the clients' contribution to the therapeutic process. Clients are seen as the primary agents of change where the role of the therapist is to be curious about the clients' competence, to balance empathetic listening to problems clients bring into therapy, and to be cognizant of the strengths, resources, or abilities that present themselves within the clients' lives.

Therapy relationship factors account for approximately 30 percent of therapy outcome. The core conditions proposed by Carl Rogers provide the basis for creating a strong therapeutic relationship. Strong relationships are formed "when clients can perceive the therapist as warm, trustworthy, nonjudgmental, and empathetic" (Miller, Duncan, & Hubble, 1997, p. 28).

Miller, Duncan, and Hubble (1997) propose that therapeutic technique contributes 15 percent to the outcome of therapy. Independent of the type of therapy employed, therapists expect their clients to do something different and to take action in order to help themselves. It is suggested that "therapists spend less time trying to figure out the *right* intervention or practicing the *right* brand of therapy and spend more time doing what they do best: understanding, listening, building relationships, and encouraging clients to find ways to help themselves" (Miller, Duncan, & Hubble, 1997, p. 30).

Hope and expectancy contribute 15 percent to the outcome of therapy (Miller, Duncan, & Hubble, 1997). Hope and expectancy are used in the therapeutic process by instilling hope and a positive expectation for client improvement. A hopeful atmosphere can be created by looking for the resources, exceptions to the problem, and having a future focus.

Miller, Duncan, and Hubble (1997) discuss Patton and Meara's (1982) research on the relationship between client satisfaction with therapy and the similarity and/or difference in the

style and structure of the client and therapist's language. Results indicate that clients are more satisfied when the therapist matches the client's language in such areas such as: word usage, complexity, depth, and meaning. The common factors model emphasizes the usefulness of looking at client's language and views it as a resource for helping therapists learn what is important and motivating to the client.

The common factors model has determined the focus in this study. Does the use of problem-focused or solution-focused language affect the client's perception of hope and the therapeutic relationship? More specifically, are there differences in the level of counselor credibility between the two types of languages or are there other factors apart from therapeutic language that relate to how clients view the therapist?

Research Questions

The first research question is: do potential clients perceive a therapist using solution-focused language as more attractive, experienced, trustworthy, and more credible than the same therapist using problem-focused language? The second research question is: what other variables affect potential clients' view of the therapist?

Hypothesis

HYPOTHESIS ONE: Participants will view the therapist using solution-focused language as more credible than the therapist using problem-focused language.

Solution-focused therapists take an active role in the goal-setting procedure and work with clients using a cooperative negotiation process. Therapists and clients work together to develop small, attainable goals. Solution-focused therapy focuses on the exceptions, solutions, possibilities, and strengths (O'Hanlon & Weiner-Davis, 1989). De Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, and Weiner-Davis (1986) discuss the importance of finding out information about the constraints of the complaint situation and attempting to create an expectation that change is not only possible, but also inevitable. According to these descriptions and explanations, solution-focused therapy incorporates the factors of hope and therapeutic relationship and also resembles Atkinson and Carskaddon's (1975) definition of counselor credibility.

CHAPTER TWO: LITERATURE REVIEW

This section aims to provide information relevant to the study. First, the researcher will describe the two models that are utilized in this study: problem-focused therapy and solution-focused therapy. The researcher will describe how therapy is conducted, the goals of therapy, the role of the therapist, and the focus of the models. The researcher also will compare and contrast the two models. Information for this section was adapted from Shoham, Rohrbaugh, and Patterson (1995).

The second section will discuss research on problem-focused therapy and its outcomes. The third section will discuss research on solution-focused therapy and its outcomes. The fourth section will discuss research on the client/therapist relationship. The fifth section will describe research that compares the two models of therapy.

Description of Problem-Focused Therapy

Included in the category of problem-focused theories are the Structural, Strategic, and Mental Research Institute models of therapy. One representative school of problem-focused therapy is the Mental Research Institute (MRI) model. The MRI model was developed in the late 1960s and 1970s by Richard Fisch, John Weakland, Paul Watzlawick, and their colleagues at the Mental Research Institute in Palo Alto. This model developed from ideas that originated in research by Gregory Bateson. Bateson's research brought about an interactional view that focused on what happens between people (Shoham, Rohrbaugh, and Patterson, 1995).

The Brief Family Center at the Mental Research Institute works with clients for a maximum of ten sessions with the use of a team setting. The team of therapists consults with the primary therapist from behind a one-way mirror. Telephone follow-up interviews with the client are conducted between three and twelve months following termination of treatment. This process was designed to evaluate the change in the presenting problems and to determine if further problems developed (Shoham, Rohrbaugh, and Patterson, 1995).

Problem-focused therapy aims to interrupt attempted solutions that ultimately maintain the problem. It aims to do less of the same, moving away from attempted solutions that have not worked to solve the problem. Problem-focused therapists adopt a cautious and restraining stance

and assume responsibility for the outcome of therapy. The focus of treatment is on current observable interactions (Shoham, Rohrbaugh, and Patterson, 1995).

The problem-focused model of therapy assumes that problems brought to treatment by the client persist only if they are maintained by ongoing current behavior. If the problem-maintaining behavior is changed or eliminated, the problem will be solved. The persistence of the problem depends on the interaction with other people. The way people try to control, prevent, or eliminate the problem plays a role in the maintenance of the problem. Therefore, this model views the problem as the attempted solution (Shoham, Rohrbaugh, and Patterson, 1995).

A problem consists of a cycle where a positive feedback loop between a behavior that is considered undesirable and some other behavior intended to modify or eliminate it. Therapy must identify and interdict these solutions and break the vicious cycles that maintain the impasse. The first stage of therapy involves identifying the cycle and creating a clear and specific picture of the behavior. Therapists will ask clients why their complaints are currently a problem and who views it as a problem. Obtaining a clear picture about who is doing what in the cycle is important to understanding the maintenance of the problem (Shoham, Rohrbaugh, and Patterson, 1995).

The next stage of therapy involves investigating behaviors that closely relate to the presenting problem. Therapists will inquire about what the clients are doing to handle, prevent, or resolve the problem and the end results of these attempts. From this stage, a clear problem-solution loop is created. These loops are the focus of the interventions, which are aimed at stopping the attempted solution and prescribing an alternative behavior (Shoham, Rohrbaugh, and Patterson, 1995).

Therapists inquire about past attempted solutions to obtain information regarding what has worked. Interventions sometimes will require suggesting an action that is doing less of the same. Throughout these interventions, the use of the client's view is fundamental. Therapists often send the message to clients to go slow, but acknowledge the clients' part in making changes. At the time of termination, therapists review what changes have been made, what the clients are doing differently, anticipate future problems, and help clients to notice their ability to handle these problems (Shoham, Rohrbaugh, and Patterson, 1995).

The therapist adopts the role of "expert" who attempts to speak the client's language and avoids arguments in therapy. The therapist also will work with the most motivated and

concerned person in the family system. Therapists do not work with clients who are reluctant, but believe that problem resolution can result from working with one person in the system (Shoham, Rohrbaugh, and Patterson, 1995).

Problem-Focused Interventions

Problem-focused therapy approaches problem with certain principles that lead to the application of a four-step procedure. The steps are as follows: (1) a clear definition of the problem in concrete terms; (2) an investigation of the solutions attempted so far; (3) a clear definition of the concrete change to be achieved; and (4) the formulation and implementation of a plan to produce this change. The first three steps aim to identify the goals of therapy and what solutions have been tried. Actual change takes place in the fourth step (Watzlawick, Weakland, & Fisch, 1974).

A variety of interventions are used in the MRI model. Reframing provides a new meaning for problem behaviors and aims to increase the likelihood of compliance. Reframes attempt to change the conceptual and/or emotional setting or viewpoint in which a situation is experienced. It is designed to place the setting or viewpoint in another frame, which fits the situation equally well or even better. The entire meaning, therefore, is changed (Watzlawick, Weakland, & Fisch, 1974).

Paradoxical interventions aim to get clients to do or believe things that are counter to common sense. These interventions are paradoxical in that people sometimes need to do things that are in opposition to their goals in order to reach them. The most common paradoxical intervention used is prescribing the symptom. In this intervention, the client is told to continue, or increase, the behavior that is considered problematic (Nichols & Schwartz, 1998).

Restraining techniques aim to reduce resistance by encouraging clients to restrain from trying to change too fast. Clients may react to this intervention by siding with one side of their ambivalence about therapy, therefore, increasing the desire for change. Therapists will encourage clients to go slowly and to worry about relapses when the improvements actually occur (Nichols & Schwartz, 1998).

Description of Solution-Focused Therapy

Solution-focused therapy was developed in the late 1970s and 1980s by Steve de Shazer and his colleagues at the Brief Family Therapy Center in Milwaukee. This model was inspired by the work at the Mental Research Institute. This model was heavily influenced by Milton Erickson's principle of utilizing what clients bring to therapy (Shoham, Rohrbaugh, and Patterson, 1995).

Solution-focused therapy aims to identify exceptions to the problem and to recognize and utilize new solutions that work. This model focuses on the exception to the problems and helping clients do more of what has already worked. The first stage of therapy begins with asking questions that help uncover the client's story. Next, goals and outcomes are discussed through the use of interventions such as the miracle question. Goals are to be small, specific, positive, behavioral, and realistic (Shoham, Rohrbaugh, and Patterson, 1995).

One goal is to identify exceptions to the problem in order to amplify new behaviors. Another goal of therapy is to reconstruct the client's view of his/her ability to resolve, control, or contain the problem. Therefore, interventions also aim to help clients recognize that problems have exceptions and to own these exceptions as solutions they have already enacted successfully. Later stages of therapy build upon and amplify what has happened. Inquiries into positive changes are conducted by the therapist. The therapist also reinforces the changes with praise and compliments (Shoham, Rohrbaugh, and Patterson, 1995).

This model is based on the complaint, but is also considered solution oriented. Therapy only addresses the complaints brought to therapy by the clients. Therapy aims to identify those solutions that have worked. The goal is to resolve the presenting complaint. Therapists work only with what problems clients bring to therapy. Therapists assume that clients want to change, and that they have effective solutions, but need assistance in recognizing them and enacting them in their everyday lives (Shoham, Rohrbaugh, and Patterson, 1995).

Therapists use questions that are past- and present-oriented in order to emphasize the possibility for change. Therapy is terminated when the problem is alleviated and the client agrees that it makes sense to stop (Shoham, Rohrbaugh, and Patterson, 1995).

Solution-Focused Interventions

The solution-focused model of therapy relies heavily on the use of specific interventions. There are several standard interventions that are commonly used in this therapy. Interventions commonly take the form of questions that aim to amplify exceptions to the problem and help clients construct a more hopeful future (Shoham, Rohrbaugh, and Patterson, 1995).

The miracle question aims to identify how a client would know that their problems are better, obtaining a clear picture of the solution. "Suppose you go home and go to bed tonight after today's session. While you are sleeping a miracle happens and the problem that brought you here is solved, just like that. Since you were sleeping, you didn't know that this miracle happened. What do you suppose will be the first small thing that will indicate to you tomorrow morning that there has been a miracle overnight and the problem that brought you here is solved?" This enables a client to obtain a clear vision of their goal. It also helps clients notice that what they want is to be able to do things that the problem prevents them from doing (Berg & Miller, 1992).

Scaling questions attempt to help clients be specific about goals, change, and progress. "On a scale of 0 to 10, where 0 represents things at their worst, and 10 represents how things will be when these problems are resolved, where would you place yourself today?" Coping questions challenge the client's belief that the situation is hopeless and implies that change may already be occurring. "How do you manage to keep going?" Presession change questions emphasize what clients may have already done. "Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed?" Formula tasks help clients become more aware of what solutions they already have in place. The formula first session task is the most commonly used formula tasks and is given to clients at the end of the first session. "Between now and the next time we meet, we would like you to observe, so you can describe it to us next time, what happens in your life that you would like to continue to have happen" (Shoham, Rohrbaugh, and Patterson, 1995).

Similarities Between Models

The first section of this chapter aims to differentiate problem-focused from solution-focused therapy. Even though these models differ on their approach to problems, they share some similarities. Both of these models aim to resolve the presenting problem quickly and

efficiently. Goals of therapy do not usually include working through emotional issues or promoting personal growth. Neither attempt to distinguish normal from dysfunctional relationships, but instead attempt to follow the client's view of the problem. The focus is on the presenting problem and possible solutions. They assume that small changes in one member of the family system can lead to further changes in the system (Shoham, Rohrbaugh, and Patterson, 1995).

Research on Problem-Focused Therapy

There has been limited research conducted on problem-focused therapy. Two studies have been located that address the effectiveness of problem-focused therapy and the outcome and length of therapy.

Outcomes and Length of Therapy

Macdonald (1994) examined outcomes of a multidisciplinary team providing brief therapy based on Fisch, Weakland, and Segal's (1982) model. Forty-one cases were used in the study. Referrals came from general practice physicians and professionals in the mental health services field. Clients were given a postal questionnaire at one year follow-up asking the following questions: (1) Is the problem solved?; (2) Were your goals for therapy achieved?; (3) Have other problems been solved at the same time?; (4) Have new problems appeared?; and (5) Has further involvement with mental health professionals been necessary? Information regarding the therapy style and setting was also obtained. General practitioners who referred the clients were also contacted and asked if the problem was better, worse, or the same. Data were obtained from 26 clients and 37 general practitioners regarding the 41 cases. In 15 cases, general practitioners replied, but the patients did not. Good outcome was reported in 29 cases (70 percent) of the 41 cases used in the study. Patients reported a good outcome in 65 percent of the cases, whereas, general practitioners reported a good outcome in 71 percent of the cases. According to the researchers, good outcome was defined as either the patient or general practitioner reporting that the problem was solved. Of the 22 cases where data were available for both the patients and general practitioners, 17 of the cases were categorized as having a good outcome. The patients and general practitioners were in agreement of a good outcome in 71 percent of these 17 cases. General practitioners only reported one case as getting worse, whereas

patients reported two cases where symptoms worsened. The average number of sessions in the good outcome group was 5.47 sessions, whereas, the average in the worsening group was 3.71 sessions.

Weakland, Fisch, Watzlawick, and Bodin (1974) examined the outcomes of problem-focused therapy for 97 cases seen at the Brief Therapy Center over a period of six years. Clients were seen once a week for an average of seven sessions. The evaluation of the outcome of treatment was based on answers to the following questions at the three month follow-up: "Has behavior changed as planned?" and "Has the complaint been relieved?" In 39 cases (40 percent), clients reported complete relief of the presenting problem. Thirty-one cases (32 percent) reported clear and considerable, but not complete, relief of the presenting complaint. Twenty-seven cases (28 percent) reported little or no such change in the presenting complaint. Only one case reported that things were worse after treatment.

Summary of Research on Problem-Focused Therapy

Research on problem-focused therapy indicates good outcomes in most cases where the either the presenting problem was relieved or solved. It was also found that the average number of sessions ranged from three to seven. This research, however, is lacking the examination of the process of therapy and the techniques utilized in the treatment. Research also lacks the use of control groups in which groups receiving problem-focused therapy were compared to groups that received no treatment.

Research on Solution-Focused Therapy

Numerous studies were located on solution-focused therapy. The following sections discuss research regarding outcomes and length of therapy, components/process investigations, and solution-focused therapy in other populations. Many studies address more than one category and will be presented in the most relevant section.

Outcomes and Length of Therapy

De Jong and Hopwood (1996) examined the outcomes for clients who requested services at the Brief Family Therapy Center from November 1992 through August 1993. Two hundred seventy-five clients were seen by one of ten therapists employed at the BFTC. Outcome was

measured by: (1) a scaling question at each session to measure ongoing client progress; and (2) a telephone survey conducted seven to nine months after the final session of therapy. Questions asked during the survey included: (1) scaling question; (2) how satisfied the client was with his/her therapy; and (3) would the client say their treatment goal was met or not met. Results indicated that 26 percent of the clients came for only one session and more than 80 percent came for four or fewer sessions. The average number of sessions was 2.9. Twenty-six of the valid cases showed no progress on intermediate outcome or they worsened, 49 percent showed moderate progress, and 25 percent showed significant progress. At the seven to nine month follow-up interview, 45 percent of the clients contacted said their goal for treatment was met, 32 percent indicated that some progress was made, and 23 percent indicated that no progress was made.

In regard to intermediate outcome, 32 percent of the clients who came for four or more sessions reported significant progress, whereas 20 percent who came for two or three sessions reported significant progress. For those clients who reported significant progress, the average number of sessions was 4.2. For those clients who reported moderate progress, the average number of sessions was 3.2. For those clients who reported no progress, the average number of sessions was 3.5. In regard to final outcome, 52 percent of the clients who came for four or more sessions reported that their treatment goals were met, whereas 41 percent of the clients who came for thee or fewer sessions reported that their goals were met. The average number of sessions for those clients who reported that their treatment goals were met was 3.7, the average number of sessions for those clients who reported some progress toward goals was 2.9, and the average number of session for those clients who reported no progress toward goals was 2.3. Researchers concluded that the same therapeutic procedures were effective across a range of client-identified problems, that effectiveness did not vary by client-therapist gender or racial mix, and that solution-focused therapy was equally effective with a diverse group of clients.

De Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, and Weiner-Davis (1986) examined the outcomes of solution-focused therapy based on client self-reports conducted six months to one year after therapy. Sixteen hundred cases seen at the Brief Family Therapy Center (BFTC) between 1978 and 1983 were studied. The average length of sessions per case was six. A representative sample of 25 percent (400 cases) was contacted for a telephone follow-up. This

sample indicated that 72 percent either met their goals for therapy or felt that significant improvement had been made so that further therapy was not necessary.

As a second part to their study, 28 of the 56 clients in an original project concerned with the formula first-session task at the BFTC were also studied. The average length of sessions per case was five. The clients were contacted between six months and one year after termination. Twenty-three of the 28 clients contacted reported that their complaint was "better." Twenty-three clients responded that the change reported in the second session was continuing. Twenty-one of the clients had mentioned a secondary complaint that was not necessarily dealt with explicitly in therapy, and 11 of these 21 clients reported that the secondary complaint was better too. Sixteen clients reported that no new problems had developed, eight reported that it was not bad enough for them to seek therapy.

Lambert, Okiishi, Finch, and Johnson (1998) examined 27 consecutive private patients seen by a group practice provider. Clients were seen by psychologists who based their treatment on solution-focused brief therapy. Participants completed between two and seven sessions and took the Outcome Questionnaire (OQ) before every session. The average number of sessions was 3.1. At the beginning of therapy, patients had a mean OQ score of 82.1. At the end of therapy, they had a mean OQ score of 60.4. A score of 63 or below on the OQ is considered within the functional range. Twenty-two of the 27 patients began treatment in the dysfunctional range. Of these 22 patients, 46 percent were considered recovered, 14 percent were considered improved, and none of the patients were classified as deteriorated.

Lee (1997) conducted a study on solution-focused brief family therapy in a children's mental health facility. Families seen by the Brief Family Therapy Team at the C. M. Hincks Centre between 1990 and 1993 were included in the study. Participants were notified that a six month follow-up would be held over the phone. A questionnaire consisting of 14 items was used to collect data about the clients' opinions about the services they received. Data from a total of 59 children and their families was collected. Sixty-four percent of the respondents reported that their goal(s) were met. The average number of sessions was 5.5 and were conducted over an average of 3.9 months. Data from the self-report revealed that 54.4 percent reported that their goal(s) had been met, 10.5 percent reported that they were partly met, 31.6 percent reported that they were not met, and 3.5 percent reported that they were unsure. Respondents reported that the most helpful element in therapy was their feeling of being supported/validated (54.4 percent),

followed by useful feedback or education, focus on the positive and useful goals, opportunity to talk, and good questioning that helped thinking.

Macdonald (1997) examined outcomes of solution-focused brief therapy with a supervised team in a mental health setting. This research serves as a follow-up to the research conducted by Macdonald (1994), which examined outcomes of a multidisciplinary team providing brief therapy based on the MRI model. Forty-seven referrals were collected over a three year period and 39 of those referrals were seen. At the one-year follow-up, clients were given a postal questionnaire asking the same questions as in the research conducted by Macdonald in 1994. Data were obtained only from 26 clients and 34 general practitioners. Follow-up information was only successfully collected for 36 cases. A good outcome was reported in 23 cases (64 percent). According to the researchers, a good outcome was defined as either the patients or general practitioners reporting that the problem was better. Eighteen patients commented on their achievement of specific goals. Of these 18 patients, nine in the good outcome group had achieved their specified goals, five had achieved part of their goals, two had achieved their goals, and two did not achieve their goals. Fewer new problems arose for the good outcome group. Three cases were reported as having a worsening of symptoms by the patients and ten were unchanged. Of these thirteen "poor outcome" cases, the duration of the presenting problem was more long-term than in the good outcome group.

Seagram (1997) examined the effectiveness of solution-focused therapy with a population of young offenders residing in a secure custody facility. Researchers hypothesized that participation in the solution-focused treatment program would result in change in the offenders' cognition, attitude, and commitment to the counseling process. Forty residents who were living in a secure custody facility for young offenders in Canada participated in the study. The treatment group consisted of 21 participants and the control group consisted of 19 participants. Treatment consisted of solution-focused individual treatment once a week for a ten-week period. Participants in the control group did not receive this treatment. Participants completed assessment packages at pre-treatment, post-treatment, and at ten-week follow-up. Treatment success was measured through: client self-report on attitude and behavior, external reports on client behaviors, and actual frequencies of behavior infractions during incarceration and post release. Members of the treatment group reported that they had made more progress in the resolution of their problems. They were also more inclined to want follow-up counseling

after their release from the facility. Further, members of the treatment group revealed greater optimism for the future relative to the members of the control group. These participants also had a greater degree of empathy for others and an increase in feelings of guilt in relation to the control group participants. Increased guilt is good in antisocial juvenile populations. There was a trend towards higher participation in treatment over time in members of the treatment group than members of the control group.

Zimmerman, Jacobson, MacIntyre, and Watson (1996) conducted an experimental study to determine if participation in a solution focused parenting group is an effective intervention for parental management of common adolescent problem behavior. The solution focused parenting group intervention was based on Selekman's (1991) six session guidelines to facilitating a group for parents of adolescent substance abusers. Participants were randomly assigned to either the experimental or control group. The experimental group consisted of 30 parents who received a six-week solution focused parenting intervention and the control group consisted of 12 parents. From the original control group of 30 parents, 12 successfully completed the posttest materials. Participants filled out two data collection instruments when initially assigned to a group, and then again after six weeks. Significant differences in the PSI were found for the following subscales: role image, rapport, communication, limit setting, and the total score. Sixty-seven percent of nine assessment items in the experimental group showed statistically significant improvement between the pretest and posttest while only one scale increased significantly for the control group.

Zimmerman, Prest, and Wetzel (1997) examined the effectiveness of solution-focused therapy in couples groups. The experimental group consisted of 23 married couples who participated in a six week solution-focused couples (SFCT) group. Treatment was based on Weiner-Davis' (1992) book and focused on individual and couple relationship strengths, improvement of communication skills, and the reduction of conflict through the use of psychoeducational materials. The control group consisted of 13 married couples who did not receive any treatment. A total of three couples from the experimental group dropped out or missed two group sessions and their testing materials were omitted from the analysis. Three instruments were used to gather data: (1) The Dyadic Adjustment Scale (DAS); (2) Marital Status Inventory (MSI); and (3) a demographic questionnaire. DAS scores were significantly different for the experimental and control groups after the completion of the solution-focused

couples group. The comparison of posttest scores suggested that couples in the experimental group experienced some benefit from being involved in the SFCT group.

Solution-Focused Components/Interventions

Research on the specific interventions and the process of therapy includes the examination of interventions such as the miracle question, pretreatment change, and solution-focused language. These components were examined in order to provide information regarding the process of solution-focused therapy.

Gingerich, de Shazer, and Weiner-Davis (1988) examined how change occurs in the therapeutic interview. The research question was: "What do therapists do that gets change, or talk about change, to happen?" Two therapeutic interviews were analyzed in this study and were coded for client and therapist content related to change. Concepts and observational codes developed from the data were designed to reflect the therapist's experience and understanding of the interview. Direct observation of client and therapist behavior was used to collect data. Client change seemed to be highest at the beginning of the interviews, tapered off during the middle, but increased at the end of the interviews. The therapist's elicitation of previous change and amplification, or reinforcement, of change occurred primarily during the first half of the interviews. Therapist's initiation, designed to initiate or prompt client change in the future, began slowly but increased steadily to the highest level at the end of the interviews. Client change was more likely to occur after therapist change-related talk. In other words, the therapist's elicitation in the previous speaking turn more than quadrupled the likelihood that client change would occur following that speaking turn. When the therapist's speaking turn included nonchange language, the client was less likely to include change talk in his or her speaking turn.

Gale and Newfield (1992) conducted a qualitative study of the therapeutic process occurring in a solution-focused therapy session. A complete one session solution-focused marital therapy case conducted by Bill O'Hanlon was analyzed using conversational analysis. Nine categories of linguistic strategies that were employed by O'Hanlon in his pursuit of a solution-focused conversation were described. The nine categories were: (1) pursuing a response over many turns; (2) clarifying unclear references; (3) modifying his assertion until he receives the response he is seeking; (4) posing questions or possible problems and answering these

questions himself; (5) ignoring the recipient's misunderstanding or rejection and continuing as if his assertion were accepted; (6) overlapping his (therapist) talk with the husband's or wife's in order to get a turn; (7) (re)formulation; (8) offering a candidate answer; and (9) using humor to change a topic from a problematic theme to a solution theme. Researchers reported that these nine categories were used in a cybernetic loop to help direct the couple's talk toward solutions.

Dine (1995) examined how the miracle question works and if this question creates a shift in people's perspective about their problems. Seven clients were either enrolled in a parent educational group, a women's support group, or a birthmother's support group, and five clients were mothers recruited by personal contact. Participants were either self-referred by the Department of Social Services in order to address problem areas in their lives or were personally recruited by the researcher. Twelve one-hour interviews were analyzed for this study. Interviews consisted of discussing a problem, asking the miracle question, and asking process questions at the end of the session in order to determine the nature of the participant's experience with the miracle question. Qualitative analysis of the data found nine themes in the participants' responses when asked the miracle question. These nine themes were: happiness, relaxation, improved self-concept, energy, freedom, better housing situation, better relationships with children, suppression of problems, and better relationships with adults. Six participants discussed their feelings of being more hopeful when they were asked about their experience of the miracle question, four participants discussed their feelings of being hopeful in a tentative way, seven participants seemed to resist the urge to get their hopes up, and one participant expressed a sense of hopelessness when discussing their experience of the miracle question. Five participants reported that they had good feelings as a result of answering the miracle question, three participants seemed to experience sadness when discussing their miracles, and two participants reported feeling angry in response to the miracle question. Four participants reported that they increased their sense of responsibility for their problems as a result of the miracle question and two participants reported that the miracle question allowed them to think about the problem in a different way. Researchers concluded that the miracle question elicits feelings of hope and being in charge of one's life.

Shilts, Rambo, and Hernandez (1997) examined client perspectives on solution-focused brief therapy and client participation in supervision. Several teams interviewed more than 50 families during a clinical practicum in a family therapy doctoral program. Separate post-session

conversations were conducted and videotaped. Trends that emerged from the interviews were examined. The first trend in the research was that many of the families reported that they appreciated those therapists who were respectful and took the time to "listen" to the families' story. According to the families, the most beneficial aspect of therapy was when the therapist appeared caring and concerned. The second trend was that the questions that were asked may be the most effective intervention. The third trend was that families appeared to find the team concept (4 to 6 therapists) with the use of the one-way mirror helpful. Families reported not being intimidated or distracted by the one-way mirror, telephone call-ins, or the use of video recording. The research did not find any consistent trends among families regarding the length of therapy. In general, families commented positively on the solution-focused brief therapy model. In regards to the specific intervention of the miracle question, several themes arose from the research. First, the families reported that this intervention helped them focus on what they hoped to accomplish in therapy. Second, many families reported that although their miracles may not have happened, the intervention instructed them to do "something different." Third, families reported that there was hope with their concerns and that they could get to a better place in their lives.

Allgood, Parham, Salts, and Smith (1995) examined the association between pretreatment change and unplanned termination. Data from 200 clients who sought therapy in a university marriage and family therapy training center from January 1991 to April 1992 were analyzed. Clients completed a pretreatment change questionnaire prior to the intake session, asking if they had seen any change since they had scheduled an appointment. Following the completion of therapy, therapists completed a termination form. This form indicated if it was either an unplanned or planned termination. Planned terminations were defined as both the therapists and clients agreeing that termination was appropriate. Thirty percent of the clients reported pretreatment change. The more sessions the clients attended, the more likely therapy resulted in a planned termination. Clients with no pretreatment change were more likely have unplanned termination. Researchers concluded that pretreatment change was associated with what is considered a desirable outcome in therapy.

Johnson, Nelson, and Allgood (1998) examined how pretreatment changes in therapy impact on the outcome variables of unplanned termination, relationship, functioning, good attainment, problem solving, and communication. Thirty-nine cases (63 individual participants)

that requested therapy at a western university's marriage and family therapy clinic between August 1994 and June 1995 and who consented to participate in the research were examined. Four instruments were used in the analysis of the data: (1) Family Assessment Device (FAD); (2) Scaling Question; (3) Global Assessment of Relationship Functioning (GARF); and (4) The Pretreatment Change Questionnaire. Cases were assigned to one of three groups: (1) pretreatment change 1 (PT1); (2) pretreatment change 2 (PT2); and (2) no pretreatment change (NP). Therapists of the PT1 group were informed of the clients' pretreatment changes and were instructed to notice these changes in sessions one to three. Therapists were instructed to listen to clients' responses, but not explore the pretreatment change further and to assign homework to continue the pretreatment change. The PT2 and NP groups were conducted as usual for three sessions and therapists were instructed to not ask about pretreatment changes. The PT1 (N=10) and PT2 (N=10) groups consisted of clients that reported at least one pretreatment change that they wished to continue. The NP (T=19) group consisted of cases that reported no pretreatment change. Results indicated that the PT1 group that reported pretreatment changes had a lower number of cases of unplanned termination. The PT2 and NP groups had similar and higher percentages for unplanned termination. Unplanned termination was defined in this research as therapy having ended without both the client and therapist agreeing that ending of therapy was appropriate. Fifty-three percent of all the cases reported pretreatment change. Clients who reported pretreatment change had higher scales on all instruments. Among those participants who reported a pretreatment change, 79 percent reported the continuation of the change after three therapy sessions.

Weiner-Davis, de Shazer, and Gingerich (1987) explored changes in problem situations that frequently occurred prior to the first session. Participants were asked the following questions in order to systematically elicit pretreatment change: (1) Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed about your situation?; (2) (if yes to number one) Do these changes relate to the reason you came for therapy?; and (3) (if yes to number one) Are these the kinds of changes you would like to continue to have happen? Thirty families seeking treatment at a community-based organization serving youth and their families were surveyed. Of the 30 parents who were surveyed, 20 reported having observed presession change. All of these

20 parents answered "yes" to questions two and three. Researchers concluded that the changes the parents observed were in, or related to, the problematic area.

Lawson (1994) examined if pretreatment change occurred between the time an appointment was made for counseling and the time clients came to the first session. Eighty-two clients who sought individual and family counseling in a three-month period from a southern university marriage and family counseling center were surveyed. Participants were asked the three questions used by Weiner-Davis, de Shazer, and Gingerich (1987). Approximately 62.2 percent of the clients interviewed (n=51) reported observing pre-session change. Approximately 37.8 percent (n=31) reported either no change or that things seemed worse. Of the 51 cases who reported pre-session change, 49 reported that the changes were related to the reason they came for counseling and were the kinds of changes they wanted to continue to happen.

Solution-Focused Therapy with Other Populations

LaFountain, Garner, and Eliason (1996) presented the concepts of solution-focused counseling as it relates to the field of school counseling. The researchers describe the basic concepts and how they apply to groups. Thirty-four counselors were randomly assigned either to an experimental treatment group consisting of an eight-week solution-focused group or to a wait-control group. Counselors conducted the solution-focused groups after receiving a full day of training in solution-focused group counseling. Counselors in the control group received the same solution-focused training as the experimental group; however, they did not conduct the group until after the conclusion of the study. Three hundred eleven students were involved in the study. One hundred thirty-five students who were on the caseloads of the counselors in the control group served as controls for those 176 students who received the solution-focused counseling group. Two instruments were used in the research: (1) Index of Personality Characteristics (IPC); and (2) telephone interviews with the counselors that collected data on the student's goal and level of attainment. Pretest and posttest measures of the IPC were collected for students in both the experimental and control groups. Goal attainment was measured on a five point scale. A rating of five on the scale was given if either a group member, teacher, or parent viewed the student as showing significant improvement outside of the group. A rating of one on the scale was given if the counselor viewed the student as not consistently showing progress toward the goal. According to the assessment of the counselor of those who achieved

their goals, 14 percent of the students achieved their goal to a very high degree, 42 percent to a high degree, 25 percent to a moderate degree, 10 percent to a low degree, and 9 percent made little progress toward their goals. Results indicated that the scores in self-perception for the students in the solution-focused groups were significantly higher than for the students in the control groups. Those involved in the solution-focused group reported more appropriate coping behavior with their emotions.

Sundman (1997) examined how the use of solution-focused ideas influences the relationship between social workers handling living allowances and child welfare issues and their clients. Ten clients were chosen at random from each social worker's caseload. Social workers were employed at a community-based social welfare office. Three hundred eight-two clients agreed to participate. The experimental group consisted of 11 social workers who were trained in solution-oriented ideas. The control group consisted of 14 social workers who continued to work as before without the solution-oriented training. The workers and their clients completed questionnaires together either at the beginning or the end of the meeting, however, clients answered one question regarding the helpfulness of the worker privately. A six-month follow-up was conducted where all workers and their clients completed a second questionnaire. Questionnaires gathered information regarding the clients' current living situation, the goals, and the means to achieving the goals. The questionnaires asked the following questions: (1) who was involved?; (2) who are the main persons?; (3) who is present now?; (4) who co-ordinates that work; (5) what is the issue now?; (6) what is the situation now?; (7) in what phase is the work?; (8) what is the goal?; (9) how far/near is the goal?; (10) what are the means for the goal?; (11) how likely is it that the goal will be reached?; (12) how much help has the worker provided? During the initial intake of data (baseline), there were more positive statements in the questionnaires about the clients' living situation in the experimental group than in the control group. The control group started with more negative statements at the baseline, however, ended with more neutral statements at the six-month follow-up. At the follow-up, differences in positive statements between the experimental and control groups were not evident. The control group saw more positive change occurring during their work, whereas, the experimental group based their work on a more positive view. The solution-focused ideas showed up as a more positive baseline, however, they did not seem to help create more change. No significant differences were found in the achievement of goals between the experimental group and the

control group. Researchers concluded that the solution-focused approach did not change the entire outcome of the client-worker relationships.

Polk (1996) examined the technique of solution-focused therapy and its application to a single case that requested assistance for the EAP program. Solution-focused treatment for a total of six sessions was conducted using the model presented by Berg and Miller (1992). Data were collected across a three-week baseline period before the beginning of the intervention and collateral reports were collected on a weekly basis. Three outcomes measures were used for this single subject design: two measured abstinence from drinking and one measured work attendance. Participants and their spouses independently recorded whether the participants had remained abstinent for each day. Work attendance was measured by the number of days the participant was present at work during a three-week period. There was a gradual increase in the days abstinent as the sessions progressed from four days per week to five and six days per week. Researchers concluded that improvement in problem drinking behaviors (measured by attendance and abstinence) correspond with the solution-focused regimen. The therapists in this study also observed an improvement in attitude towards work during the treatment period.

Cockburn, Thomas, and Cockburn (1997) examined variables associated with the psychosocial adjustment of work hardening program participants. Work hardening programs provide rehabilitation treatment and work re-entry for patients receiving worker's compensation. Forty-eight work hardening participants were randomly assigned to one of four groups at their initial functional capacity examination. Treatment Group 1 consisted of participants who were administered a Family Crisis Oriented Personal Evaluation Scales (F-COPES) pretest and posttest and provided with six weeks of solution-focused therapy. Control Group 2 consisted of participants who were administered an F-COPES pretest and posttest and provided with the standard rehabilitation protocol. Treatment Group 3 consisted of participants who were administered an F-COPES posttest only and provided with six weeks of solution-focused therapy. Control Group 4 consisted of participants who were administered an F-COPES posttest only and provided with the standard rehabilitation protocol. Two instruments were used in the analysis of data: Family Crisis Oriented Personal Evaluation Scales (F-COPES) and Psychosocial Adjustment to Illness Scale-Self Report. The F-COPES determines problem solving and behavioral strategies utilized by individuals in difficult contexts. The Psychosocial Adjustment to Illness Scale-Self Report identifies specific domains of adjustment in respect to a

medical condition. All groups received the Psychosocial Adjustment to Illness Scale-Self Report at the time of the F-COPES posttest. Sixty-eight percent of patients participating in the treatment group returned to work in less than seven days after discharge, whereas 4 percent of the control group returned to work. At the time of the follow-up, 21 percent had not been back to work and 30 percent had returned to work in excess of 30 days. Improved psychosocial adjustment to their spouse's current medical condition was found with the couples assigned to the treatment group. It was proposed that solution-focused therapy in conjunction with work hardening protocols is effective for patients in developing effective coping skills with stressors associated with rehabilitation.

Schorr (1997) examined how a solution-focused approach affected an anger group. An eight-week anger group was the focus of treatment. The group utilized a solution-focused approach plus skills training derived from cognitive behavioral research. The solution-focused techniques of scaling, miracle question, and exception finding question, were used in the treatment. The miracle question was used in order to clarify goals. Exception finding questions were also used in order to find solutions. The group originally consisted of five men and eight women, but ended with only three men and six women. A State-Trait Anger Inventory (STAXI) was used to assess levels of anger. At the time of the pretest, 67 percent were at the 75^{th} percentile or above. Individuals with scores at the 75^{th} percentile are likely to be hindered by their anger and experience difficulty in interpersonal functioning. At the time of the post-test, only 40 percent were at the 75^{th} percentile on the STAXI. Results of an evaluation questionnaire completed by the clients indicated that they had noticed changes in their behavior, thinking, and/or feelings since participating in the anger group.

Lindforss and Magnusson (1997) conducted research with a criminal population in Swedish prisons. This population consists of prisoners who often return to prison as many as three times per year, have long histories with drug misuse, and have many contacts with various social welfare agencies. A solution-focused brief therapy approach with a focus of networks was used. Networks were made up of people significant to the participants and who took part in the therapeutic work by attending the meetings. The experimental group consisted of 30 persons who received solution-focused brief therapy network treatment, and the control group consisted of 30 persons. Measurement of the dependent variable, recidivism, was made after 12 and 16 months. At the 12-month follow-up, 53 percent in the experimental group had committed a new

offense that lead to imprisonment or probation, while 76 percent of the control group had done so. At the 16-month follow-up, 60 percent of the experimental group had committed a new offense, while 86 percent of the control group had done so.

Eakes, Walsh, Markowski, Cain, and Swanson (1997) examined the impact of a brief solution-focused model on both individual psychopathology and the social climate of families dealing with schizophrenia. Ten clients diagnosed with schizophrenia and their family members were studied. The control group consisted of five clients who received traditional outpatient therapy and the experimental group consisted of five clients who were treated with a BSFT model. Participants completed The Family Environment Scale at the beginning and end of treatment. Five sessions of treatment were provided over a period of ten weeks. Scores on the expressiveness and active-recreational orientation scale increased for the experimental group on the post-test, while the control group scores decreased. The increased scores indicate a healthy change in the control group towards higher levels of expressiveness and participation in social and recreational activities by the family members. For the moral-religious emphasis score, scores remained the same for the experimental group, but increased for the control group. Researchers concluded that the increase for the control group may reflect a sense of not being able to fight the illness that warrants putting faith into another dimension, while the lack of movement for the experimental group may reflect a belief in the ability to handle the problems associated with schizophrenia. For the incongruence scale, scores increased for the control group on the post-post, but decreased for the experimental group. The decrease in scores on the incongruence scale reveal that the experimental group increased their agreement on the social climate dimensions, while the control group decreased their agreement.

Research on Client-Therapist Relationship

Since the theoretical framework utilized in this research is based on the common factors model, research examining therapist-client relationship is relevant. Only studies on the therapist-client relationship in solution-focused therapy were located. These studies provide the reader with information on how relationship factors play a role in solution-focused therapy. Studies on the therapist-client relationship in other therapeutic models are not described.

Beyebach, Morejon, Palenzuela, and Rodriguez-Arias (1996) describe research

undertaken over a period of ten years. This study examined what happens between therapists and clients in the course of brief therapy and analyzed the interactional context in which dropping out of treatment occurs. Ninety-seven subjects seen over a three-year period at a private brief psychotherapy center in Salamanca, Spain were sampled. Subjects received an integration of solution-focused and MRI problem-focused brief therapy approaches. The approach is described as brief therapy that focused both on solutions and on the complaint pattern. The average length of therapy for this sample was five sessions. At the time of termination, 71 percent of the subjects reported either the complete disappearance of their complaints or a clear improvement. At the 6-35 month follow-up, 12 percent of the successful cases were rated as relapses. Thirty-eight percent of the clients reported that additional positive changes had taken place. Dropout was defined as an interruption of treatment that occurred on the part of the client without the agreement by or the acknowledgement of the treating therapist. Sixteen cases were chosen from all the cases with an individual format in which dropout did not occur and sixteen cases were chosen from all the cases in which dropout did occur. Each dropout case was matched with a non-dropout case treated by the same therapist or therapists of the same gender. Thirty-two interviews were conducted. The Heatherington and Friedlander (1987) F-RCCCS version of the RCCS was used in the analysis of the data. This instrument involves coding each intervention of the speakers, developing a set of rules that are used to transform codes into control codes, and then passing from the monadic to the dyadic level. Researchers concluded that the differences between the dropout group and the continuation group seem to be related to the information-gathering phase of therapy. In the interviews after which dropout took place, the client interrupted the therapists with much greater frequency, disapproved more, and gave and received less support than in the continuation group. Clients in the dropout group were more domineering and insistent on assuming a superior position in the communicative exchange than in the continuation group. The findings from the study suggest that therapists from the dropout group did not handle the domineering behavior of their clients adequately and had a difficult time entering into opposition. The therapist-client interaction that occurred in the session preceding dropout was less harmonious and more conflictual.

Metcalf, Thomas, Duncan, Miller, and Hubble (1996) examined client and therapist perceptions regarding solution-focused therapy (SFBT). Six cohabitating couples and their therapists at the Brief Family Therapy Center participated in the study. Participating

couples were viewed by both therapists and couples as having terminated therapy successfully. Data were collected through separate interviews with couples and their therapists. The study employed an analytical, constant comparative approach to the data. The central interview question to the couples was: "What was it that occurred in the therapy process that you found the most helpful?" The central question to the therapists was: "What did you find in the therapy process that seemed to help change occur?" Results indicated that, in general, therapists were seen as more active and directive by the clients than by the therapists. Of the eight categories identified by clients, five referred to the therapist's active role in terms of providing guidance or suggestions. Only one of the eight categories that emerged from the therapist interviews reflected a directive or advice-giving therapeutic stance. Clients perceived the process of therapy as characterized by suggestions, pointing things out, and teaching, while therapists reported that listening, collaborating, observing and reinforcing strengths, and not making suggestions were parts of the therapeutic process. Researchers concluded that the clients' perception of the therapists' role differed significantly from the therapists' self-description and the philosophy of SFBT. The reasons given by the therapists and clients for the clients seeking services were similar; however, the language used in the descriptions was not. Therapists relied on professional jargon, speaking of symptoms, disorders, dysfunctions, and discord. Therapists viewed the decision to terminate as agreed upon, whereas many clients felt it was unilaterally the therapist's decision. In regard to the change process and what worked in SFBT, similar perceptions of the change process emerged from both client and therapist interviews: amplifying strengths, praising, noticing differences, and focusing on what worked. However, therapists more often mentioned technique as critical factors while clients more often mentioned relationship factors.

Metcalf and Thomas (1994) conducted a qualitative study at the Brief Family Therapy Center on client and therapist perceptions of solution-focused brief therapy. Six cohabitating couples ages 25-65 and their therapists were interviewed at the BFTC. Couples who were chosen to participate, in the view of their therapist, had completed and terminated therapy successfully. Participants had received at least two years of solution-focused brief therapy. Researchers asked the six couples the following question: "What was it that occurred in the therapy process that you found the most helpful?" They asked the six therapists the following question: "What did you do in the therapy process as the therapist that seemed to help change

occur?" The data were analyzed through the use of constant comparative approach. Results indicated that four out of six couples' descriptions regarding what was helpful in inducing change differed from the therapists' descriptions. Two out of six couples' descriptions were similar to their therapists' descriptions. Couples indicated that listening, amplifying strengths, reinforcing, point out things differently, praising, noticing differences, and questions worked in the change process. Therapists indicated that punctuating the experience, showing up, validation, empowering and finding resources as well as active participation, separating the kids from mom, and helping to figure out goals worked in the change process. Therapist and client responses to questions about the process of therapy were similar in their description of reinforcement, listening, and focusing. Couples described the therapists as more active in the therapeutic process than the therapists. Couples indicated that the active roles of the therapists were helpful and important to the therapeutic process.

Summary of Research on Solution-Focused Therapy

Researchers have suggested that solution-focused therapy is effective for a range of client populations. Reported success rates range from 60 percent to 75 percent. Success typically was rated according to whether participants met their goals of therapy, made significant improvement on their goals, or partly met their goals.

There are many strengths of the research on solution-focused therapy. The research has examined a wide range of client populations. Studies also have examined the solution-focused model in disciplines other than marriage and family therapy. Studies have investigated work hardening programs, criminal populations, anger management groups, youth offenders, social work and child welfare, and school counseling. Studies also have looked at the improvement of patients experiencing specific mental health disorders including schizophrenia and substance abuse. The research has provided some evidence that solution-focused therapy is a useful and brief therapeutic model.

There also are weaknesses of the research on solution-focused therapy. Most of the studies lack control groups where participants are assigned either to solution-focused therapy, other models of therapy, or no treatment. Most of the studies also lack random assignment of the participants and rely on self-report measurements. The research does not address the client or participant's view of the overall solution-focused model. Studies on the therapist-client

relationship briefly discuss what components clients find helpful to the therapeutic process; however, specific research is lacking on how clients rate the model's effectiveness.

Research Comparing Problem-Focused and Solution-Focused Therapy

Adams, Piercy, and Jurich (1991) investigated the immediate impact of a solution-focused therapy intervention on the family and the therapist. The study examined the effects of the formula first session task in addition to the formula first session task plus solution-focused therapy in comparison to a standard problem-focused structural-strategic intervention. Forty-five couples and families from a university marriage and family therapy center and 15 families from a social services agency who participated in therapy between January 1988 and May 1989 were studied. This study used a three-treatment group, follow-up experimental design with random assignment of the 60 families to each therapist (N=15) and the three treatment groups. The three treatment groups were: (1) the formula first session task (FFST) followed by problem-focused therapy; (2) the FFST followed by solution-focused therapy; and (3) a problem-focused intervention (PFT) followed by problem-focused treatment. Data were collected using the following assessment instruments: (1) Compliance Rating Scale; (2) Termination Status Form; (3) Pretreatment Status Form; and (4) Immediate Outcome Rating Scale. The control group consisted of 20 families who were given the following problem-focused task (PFT): "Between now and the next time we meet, we would like you to observe, so that you can describe to us next time, the problem(s) occurring in your (pick one: family, life, marriage, relationship)." The second and all subsequent sessions were conducted from a problem-focused structural-strategic orientation. The average number of treatment sessions in this control group was 11.5 sessions. The first experimental group consisted of 20 families who were given the FFST at the end of their first session. The second and all subsequent sessions were conducted using a solution-focused orientation. The average number of treatment sessions in this experimental group was 8.85. The second experimental groups consisted of 20 families who were given the FFST at the end of their first session. The second and all subsequent sessions were conducted from a problem-focused structural-strategic orientation. The average number of treatment sessions in this experimental group was 8.9. Goal clarity and compliance were found to be significantly higher for the FFST followed by solution-focused session and the FFST only compared to the problem-focused treatment. Results did not find that the two solution-focused

groups were significantly different for either goal clarity or compliance. A larger proportion of therapists rated the problem as improved in the FFST group (60 percent) than in the PFT group (25 percent). A larger proportion of observers rated the problems as improved in the FFST only group (55 percent) than in the PFT group (15 percent). Researchers reported that families who had received the FFST were more compliant with this task than families receiving the PFT. Families reported a clearer sense of the treatment goals following the FFST and significant improvement in the presenting problem. However, the FFST did not influence the outcome of treatment measured at the tenth session. Families who were given the FFST at the end of their session complied more easily with the task than did the families who were given the PFT. FFST families returned to the second session reporting both clear treatment goals and improvement in the presenting problem.

Jordan and Quinn (1994) examined how the problem-focused and solution-focused approaches to therapy differed. The problem-focused approach in this study used the following interventions: (1) a problem-oriented question; and (2) the problem-focused Formula First Session Task (PF-FFST). The PF-FFST was introduced to clients as follows: "Between now and the next time we meet, I want you to watch closely, so you can describe to me next time, what happens in your (family, life, marriage relationship) when this problem next comes up; that is, who does what before, during, and after the problem behavior." The solution-focused approach in this study used the following interventions: (1) the miracle question; (2) the exception question; and (3) the solution-focused Formula First Session Task (SF-FFST). The SF-FFST was introduced to clients as follows: "Between now and the next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your (family, life, marriage relationship) that you want to continue to have happen." Forty subjects consisting of families, couples, and individuals in brief family psychotherapy seen by doctoral level students at a training clinic were randomly assigned to one of 13 therapists. The problem-focused group consisted of a total of 25 participants (eight individuals, seven couples, and one family). The solution-focused group consisted of 15 participants (eight individuals, three couples, and one family). A one-year follow-up evaluation was conducted. Four instruments were used in the collection and analysis of data: (1) Treatment Adherence Form; (2) Working Alliance Inventory (WAI); (3) Session Evaluation Questionnaire (SEQ); and (4) Handy Outcome of Psychotherapy and Expectancy Scale (HOPES). No significant overall differences were

found between the problem-focused and solution-focused approaches on the WAI and HOPES. Significant overall differences were found between the problem-focused and solution-focused approaches on the SEQ. The SEQ measures the variables of session depth, session smoothness, session positivity and session arousal. Session depth was perceived by the clients as greater in the solution-focused approach. Session smoothness and session positivity scores were greater for the solution-focused approach. Significant differences were found between the problem-focused and solution-focused approaches on two constructs of the HOPES: client's perceived problem improvement and outcome expectancy. Researchers concluded that both treatment approaches advocate the need to allow clients to move through the process of goal identification, emphasize attention to what needs changing, and help the client create a more workable goal which results in the hope for problem improvement. Researchers speculated that clients in the solution-focused therapy may become more optimistic as a result of the focus of the second session, develop a sense of competence as a result of solution talk, and begin to open up an awareness of the possibilities that had previously not been available.

Using the data from their 1994 study, Jordan and Quinn (1997) examined the variable of gender as it related to specific treatment approaches. Significant differences were found between male and female clients for the variables of: (1) outcome optimism; (2) self-efficacy; (3) outcomes expectancy; (4) session positivity. With regard to outcome optimism, female clients were more inclined to expect positive outcomes from therapy than the male clients. Researchers concluded that female clients tended to view more positively the possibilities for their own change compared to male clients. Women were more optimistic about successful outcome than were men. Females in the study felt more positive about their sessions than did males. Even though differences were found by client gender, there were no significant differences found for client gender by treatment approach for the variables of outcome optimism, self-efficacy, outcome expectancy, and session positivity. No overall significant differences were found between male and female clients on the three scales (WAI, HOPES, and SEQ). No overall significant differences were found between client gender by treatment approach on the three scales. Researchers concluded that female clients were more inclined to expect positive outcomes from therapy, to view more positively the possibilities for their own change, to be more optimistic about therapy, and to be more positive about their sessions.

Speicher-Bocija (1999) examined in-session immediate process variables and post

session intermediate outcome of brief therapy approaches. Twenty outpatient clients from a family service agency participated in the study. Clients were randomly assigned to one of six agency therapists for the intake session and then were randomly assigned to one of the two treatment conditions: solution-focused or problem-focused. Therapists were trained over a five-month period. Five instruments were used to collect data: (1) The Self-Efficacy Scale (SE scale); (2) The Counseling Goal Self-Efficacy Scale (CGSE); (3) Internal Control Index; (4) Post-Session Questionnaire; and (5) Brief Therapy Content Coding System. Neither client nor therapist response modes were able to predict posttest general self-efficacy. Response modes were developed by the Brief Therapy Content Coding System in order to analyze the content of therapist and client verbalizations. There were no improvements in prediction of posttest self-efficacy over pretest self-efficacy by knowledge of treatment type or internal locus of control. Treatment type did not predict posttest scores on counseling goal self-efficacy. Clients in the solution-focused treatment group commented on the value of focus and goal setting while those in the problem-focused treatment group commented on the usefulness of insights into their behavior. Researchers concluded that clients ranked the solution-focused sessions as focusing somewhat more on goals than concerns while they ranked the problem-focused sessions as focusing slightly more on concerns than goals. Clients in both session types reported that their confidence about solving the presenting problem had increased. Clients in both interview types reported positive counseling experiences. Those clients in the solution-focused sessions sanctioned the usefulness of focus and goal setting. Those clients in the problem-focused sessions described the value of insights into their behavior. Overall, both groups reported an appreciation of the therapist behaviors of understanding, support, assurance, provision of materials, offers of direct assistance, and input on behaviors.

Sundstrom (1993) examined the effects of a single session of problem-focused psychotherapy versus a single session of solution-focused psychotherapy on depressed mood, self-esteem, and client ratings of counselors. A total of 40 female students scoring from 12-29 on the Beck Depression Inventory (BDI) participated in the study. These students were seen individually for a single session and were randomly assigned to one of the two treatment groups: (1) solution focused; and (2) problem-focused. The problem-focused treatment explored the client's problem(s) and is based both on standard therapeutic procedure and Interpersonal Therapy of Depression. The solution-focused treatment highlighted the client's resources and

previous or current coping strategies that were successful. Five instruments were used to assess change: (1) The Beck Depression Inventory (BDI); (2) The Depression Adjective Checklist (DACL); (3) The Rosenberg Self-Esteem Scale (SES); (4) The Inventory to Diagnose Depression (IDD); and (5) The Counselor Rating Form-Short Form (CRF-S). Thirty-two percent of the sample met the diagnostic criteria for Major Depression according to the IDD. Researchers found no significant differences in the reduction of depressive symptoms between the problem-focused and solution-focused treatment conditions. In addition, there were no significant differences in counselor credibility, as measured by the CRF-S, as a function of treatment condition.

Littrell, Malia, and Vanderwood (1995) examined how three different treatment approaches related to the attainment of goals in a high school counseling setting. Both quantitative and qualitative methods were used to explore the aspects of single-session brief counseling. Participants were randomly assigned to one of three groups: (1) a problem-focused brief counseling approach with a task; (2) a problem-focused brief counseling approach without a task; and (3) and a solution-focused brief counseling approach with a task. The modified control group consisted of the problem-focused approach without task. Data for 61 students who voluntarily made appointments with their high school counselors were obtained. Two follow-up interviews at two and six-week intervals post-treatment as well as data from the counseling sessions were analyzed. Across the three approaches at the first follow-up, 75 percent of the students had reached 50 percent or more of their goal. Across the three approaches at the second follow-up, 90 percent of the students had reached 50 percent or more of their goal. The intensity of undesired feelings from before the counseling session through the second follow-up dramatically decreased. Overall, the three brief counseling approaches did not differ in alleviating students' concerns. Even though the solution-focused group mean percentage for goal attainment was the largest, the researchers concluded that all three counseling approaches were successful in moving students in the direction of their goals.

Summary of Research on the Comparison of the Models

Research on the comparison of problem-focused therapy and solution-focused therapy suggests that there are no differences between the two in the outcome of therapy. The research suggests that both models provide a positive experience of counseling, successful movement

towards goals, and confidence in the resolution of the problem in the clients. However, significant differences between the problem-focused and solution-focused models have been found in some areas of therapy process such as: goal clarity, treatment compliance, outcome expectancy, session impact, and the therapeutic focus.

A strength of this research is that it examines how the two approaches differ on the outcomes of therapy. The studies have focused on the exploration of the specific techniques of the solution-focused formula first session task and the problem-focused formula first session task. Although not many studies compare solution-focused and problem-focused models, the research design of the studies that do is strong. Many studies used random assignment to treatment groups and measure outcome by means of standardized measures. The treatment models used in the research have also been consistent.

A weakness of this research is the lack of examination into how clients and participants view the overall models, the focus of each model, the techniques of the models, and the differences between them. Minimal research is available on the client's perception of the models and the therapist using these models. The research has primarily examined the outcome of these models within the general population; however, research is lacking on the comparison of the models with specific populations.

CHAPTER THREE: METHODS

The purpose of this study is to investigate how potential clients perceive those therapists who use problem-focused and solution-focused language. Participants from two undergraduate classes at a southeastern state university were assigned to one of two groups: problem-focused and solution-focused. Participants viewed an eight-minute videotape of a role-played therapy session of the same therapist either using problem-focused therapy or solution-focused language.

RESEARCH QUESTIONS: 1. Do potential clients perceive a therapist using solution-focused language as more attractive, experienced, trustworthy, and more credible than the same therapist using problem-focused language? 2. What other variables affect potential clients' view of the therapist?

HYPOTHESIS ONE: Participants will view the therapist using solution-focused language as more credible than the therapist using problem-focused language.

Participants

This sample was a convenience sample based on membership in two classes whose instructor volunteered to participate in the research. Participants were 73 undergraduate students at a southeastern state university. These participants were both men and women enrolled in an undergraduate human services level course in the Human Development Department during the spring semester of 2001. Participants were asked to participate in a study during regular class hours. Data were collected from each class.

Sample Recruitment

An e-mail was sent to all faculty in the Human Development Department at Virginia Polytechnic Institute and State University requesting their assistance in the research. One professor immediately indicated interest. A description of the research, its purpose, and the sample being sought was given to the professor. The professor expressed interest in participating in the research and offered the two undergraduate level courses she was currently teaching. A date to conduct the research was set after the videotapes were completed and the Informed Consent was accepted by the Institutional Review Board of Virginia Polytechnic Institute and State University.

Procedures

Videotape Development

Two videotapes were created as the basis for comparison between solution-focused and problem-focused languages. One videotape contained a brief initial session of problem-focused therapy and a second videotape contained a brief initial session of solution-focused therapy. Both tapes used the same therapist, same actors as the client couple, and contained the same introduction and conclusion. The only difference was the therapeutic approach used in the actual clinical session. Clinical sessions were role-played. The development of the videotapes took place over approximately two months. First, an outline was created that discussed the purpose of the initial session for problem-focused and solution-focused therapies. Second, a more detailed outline was created that summarized the questions to be asked during the videotape. These outlines were adapted from Jordan and Quinn's (1994) outline of the initial two sessions of treatment used in their research.

The thesis chair then reviewed these outlines. Revisions were made and a detailed vignette was developed. After the thesis committee reviewed the vignette, the videotapes were created. The same therapist and couple were used in both videotapes. The tapes were created on the same day in order to control for the dress of the therapist and couple.

The videotapes were edited so each was approximately eight minutes in length. Once the editing was complete, these videotapes were viewed by two of the committee members. One committee member is trained as a strategic therapist under Jay Haley. Another committee member has conducted extensive research on solution-focused therapy and is considered highly knowledgeable about the solution-focused model. The three committee members determined that no further editing was needed and that the tapes reflected the purpose and focus of problem-focused and solution-focused therapies (See Appendices E and F for transcripts of both tapes).

The individual who played the therapist in the videotapes is trained in a variety of therapeutic models and has twenty-six years of experience in both academic and clinical settings. The individuals who volunteered to play the roles of the couple in the videotapes are current masters students in the marriage and family therapy program. The same therapist was used in both videos so that personal characteristics of the therapist would not confound the results. Likewise, the same couple was used in both videos so that couple characteristics would not be a

confounding variable. Having the videos similar with regard to variables other than therapist language helped control for other confounding variables.

Videotape Administration

During the course of one day, the researcher conducted the research in two undergraduate level classes. The entire 50 minute class time was spent collecting data. There was approximately one hour in between the two classes. The first class watched the video where the therapist used solution-focused, future oriented, and exception finding language. The second class watched a video where a therapist uses problem-focused, past oriented, and problem oriented language. A coin toss determined the selection of the videotape to be shown to the first group.

The researcher began by introducing herself, explaining the research, procedures, compensation, and research approval. The same introduction and research description were used in each class (See Appendix D). After reading the introduction and description, the researcher asked if any of the participants had any questions. Participants then signed the Informed Consent Form. They were then shown one of the two videotapes.

After viewing videotapes, participants were asked to complete the questionnaires. Once completed, they were given to the researcher. Participants were offered the opportunity to ask any questions. The data collection process took approximately 30 minutes. After the completion of the data collection, the researcher discussed the purpose of the study. Participants were also shown a brief clip of the videotape not shown. Discussions were then held to give participants the chance to discuss how they felt about the two different models.

Instruments

Three instruments were used to collect data. The Demographic Questionnaire was used to gather general information regarding the participants. The Counselor Rating Form-Short Version (Corrigan & Schmidt, 1983) asked participants to rate the counselor's credibility. Finally, three open-ended questions asked what participants liked most and least about the therapist and how likely they would be to seek out services from the therapist if they had a relationship problem.

Demographic Questionnaire

This questionnaire asked general demographic questions including: age, gender, marital status, race, academic standing, major, and whether the participants had ever been in counseling or therapy. The demographic information provided by the participants was used to determine if there were differences in responses between: males and females, ethnic groups, age groups, marital status, education level, major, and past counseling/therapy (see Appendix B for the Demographic Questionnaire).

Counselor Rating Form – Short Version

The Counselor Rating Form – Short Version (CRF-S) was used to measure participants' views of counselor credibility. It was designed to be used based on the observation of a videotaped therapy session. This form has been used in various studies to determine whether or not research participants perceive counselors as credible. It has also been tested on nonclient samples where it was determined that the measure yields similar results in both client and nonclient samples (Tracey, Glidden, & Kokotovic, 1988). The CRF-S consists of three subscales: counselor attractiveness, counselor expertness, and counselor trustworthiness.

The Counselor Rating Form-Short version was adapted from the Counselor Rating Form (CRF). The CRF was created by Barak and LaCrosse (1975) from a list of 83 adjectives. Thirty-six adjectives were chosen and each were given antonyms; for example, alert-unalert (Barak & LaCrosse, 1975). These adjectives describing the qualities of the counselor were grouped into three dimensions: attractiveness, expertness, and trustworthiness. For each item pair, a 7-point Likert scale was constructed (Barak & LaCrosse, 1975).

To create the CRF-S, the negative adjectives were dropped from the CRF scale. According to Corrigan & Schmidt (1983), "elimination of the negative adjectives was intended to increase the variance in ratings by decreasing the socially undesirable connotations of the negative adjectives in many CRF items" (p. 65). The CRF-S uses a 7-point Likert scale anchored by the words "not very" and "very". The endpoint of "very" is scored with a 7, while the endpoint of "not very" is scored with a 1. Each subscale consists of four items and is scored by summing the scores. Subscale scores can range from 4-28. The higher the score on the subscale, the more the participant perceives the counselor as being either attractive, experienced

(expert), or trustworthy. Permission was given by the scale's originator to use this instrument in this research (see Appendix C for the Counselor Rating Form – Short Version).

Many studies assessed the reliability of this instrument (Corrigan & Schmidt, 1983; Ellingson & Galassi, 1995; Tracey, Glidden, & Kokotovic, 1988; Ponterotto & Furlong, 1985; Epperson & Pecnik, 1985). Reliabilities (Cronbach's alpha) for the attractiveness subscale range from .84-.92, the expertness scale range from .84-.93, and the trustworthiness subscale range from .79-.92 (Corrigan & Schmidt, 1983; Ellingson & Galassi, 1995; Tracey, Glidden, & Kokotovic, 1988; Ponterotto & Furlong, 1985).

Qualitative Data

Finally, three open-ended questions were asked in order to obtain narrative information regarding how the participants viewed the therapist in the videotape. These questions were: (1) What did you like the most about this therapist?; (2) What did you like the least about this therapist?; and (1) How likely would you go to this therapist? Please explain.

The first and second questions asked participants to explain what they liked most and least about this therapist. These data were used to determine if other variables played a role in how the participants viewed the counselor's credibility. These data also were used to explore whether variables not related to the type of therapy used affected the results.

The third question asked participants to rate on a 7-point likert scale how likely they would go to this therapist in order to seek out counseling or therapy. Participants then were asked to explain their rating. The numerical ratings were used as a general measure of participants' confidence in the therapist.

Design and Analysis

This study is a posttest only quasi-experimental design. It is intended to compare two types of therapeutic languages: solution-focused and problem-focused. The independent variable is type of therapeutic language employed. The dependent variable is the rating of counselor credibility measured by the CRF-S. Classes were randomly assigned to one of two groups: the group watching and answering questions on the solution-focused therapy tape or the group watching and answering questions on the problem-focused therapy tape. Random assignment of

videotapes was determined through a coin toss. Although classes were randomly assigned, participants were not.

The first step in analysis was to investigate possible differences between the experimental groups. The variables tested included age, gender, marital status, race, academic standing, major, and previous counseling/therapy. T-tests were used to compare groups on continuous variables and Chi-square tests were used to compare groups on categorical variables.

Next, reliability on the instruments was examined. Cronbach's Alpha was calculated for the complete CRF-S and for each of the three subscales. These statistics provide evidence for the reliability of the instrument in this sample.

The third step involved testing the main hypothesis by comparing the solution-focused and problem-focused groups on the three subscales of the CRF-S and on participants ratings of whether or not they would seek out services from this therapist.

Finally, qualitative data obtained from the participants were examined. Responses were studied in order to determine if similar categories existed. Categories were then developed and responses were coded according to the appropriate category or categories. Data were cross-coded by a second person. The two coders differed on two of the participants' responses. These coders agreed on which categories seemed most relevant to these two responses. These data were used to determine if other variables influenced how participants viewed the therapist. Chi-square tests were conducted to determine if there were differences between groups in regards to distributions of categories used and if there were differences in which categories the participants cited to express what they liked most and least about the therapist.

CHAPTER FOUR: RESULTS

The purpose of this study is to investigate how potential clients perceive those therapists who use problem-focused and solution-focused language. Participants from two undergraduate classes at a southeastern state university were assigned to one of two groups: problem-focused and solution-focused. Participants viewed an eight-minute videotape of a role-played therapy session either using problem-focused or solution-focused language. Participants then rated the counselor credibility according to what they viewed in the videotape. They then answered three qualitative questions that asked them to discuss their rating on how likely they would be to seek out services from this therapist and what they liked most and least about this therapist.

Once the data were collected, they were analyzed. First, the researcher examined the characteristics of the sample. This included calculating the frequencies of the variables of: age, gender, marital status, race, academic standing, major, and previous counseling/therapy. Second, the researcher examined the level of counselor credibility between the two groups: problem-focused and solution-focused. Third, the researcher studied the responses to the qualitative data collected and how the data related to the rating of counselor credibility.

Characteristics of Participants

Characteristics of Overall Sample

The overall sample consisted of 73 undergraduate students in the Human Development Department of Virginia Polytechnic Institute and State University. The Human Development Department at Virginia Polytechnic Institute and State University provides two programs that lead to a Bachelor of Science. They are: Human Services and Early Childhood Education. The Human Services program is suited for those students interested in a wide variety of careers and graduate school programs. The program provides students with education in child and adult development and family and relational dynamics. Classes cover areas including: how individuals and families develop over the life cycle, issues and events that influence families, and family transitions. The program also focuses on family diversity, human sexuality, and social and public policies (See Table 4.1 for a summary of the demographic characteristics of the sample).

Characteristics of Problem-Focused Group

The problem-focused group consisted of 38 undergraduate students. These students were enrolled in HD 2336 – Principles of Human Services. This course is a continuation of HD 2335, a prerequisite for HD 2336. Students are taught basic concepts, techniques, and structure of the human services profession. This class examines some of the theories supporting different techniques and practices in human services and exposes students to program design and grantmanship. The learning objectives for this course include: (1) describe the basic concepts and frameworks of the human services profession; (2) apply theories and research in assessing individual and family functioning; (3) apply theories in understanding different approaches to delivering human services; (4) implement a problem solving approach to defining human needs and appropriate interventions; (5) identify formal and informal social support networks and human service intervention systems; (6) describe a variety of interventive practice models and demonstrate knowledge of how and when to use these models; (7) describe principles of how to work with families and individuals with diverse backgrounds, needs and resources; (8) demonstrate knowledge of issues surrounding resource development and evaluation; and (9) analyze ethical and professional issues facing human service workers. Instruction is given on the survey of client/family assessment and problem management. Students in this course typically are upper level undergraduate students who have completed two courses prior to enrollment – HD 1005 and HD 2335 (See Table 4.1 for a summary of the demographic characteristics of the group).

Characteristics of Solution-Focused Group

The solution-focused group consisted of 35 undergraduate students. These students were enrolled in HD 2335 – Principles of Human Services. This course is one of two courses taught on the topic of Principles of Human Services. The prerequisite for this course is HD 1005. Students are taught basic concepts, techniques, and structure of the human services profession. This class provides an overview of the field and examines the philosophies behind the helping professions, the source of authority for these professions, and the many different arenas in which these professionals work. The learning objectives for this course include: (1) describe the basic concepts and frameworks of the human services profession; (2) apply theories and research in assessing individual and family functioning; (3) apply theories in understanding different

approaches to delivering human services; (4) implement a problem-solving approach to defining human needs and appropriate interventions; (5) identify formal and informal social support networks and human service intervention systems; (6) describe the interface between government policy and the human service profession; (7) describe a variety of interventive practice models and demonstrate knowledge of how and when to use these models; (8) describe principles of how to work with families and individuals with diverse backgrounds, needs and resources; (9) demonstrate knowledge of issues surrounding resource development and evaluation; and (10) analyze ethical and professional issues facing human service workers. Students in this course are typically lower level undergraduate students (See Table 4.1 for a summary of the demographic characteristics of the group).

Table 4.1
Demographic Information of the Participants

	Age	Gender	Marital Status	Race	Academic Standing	Academic Major	Previous Therapy
Problem-Focused Group	19-35	36 Female 2 Male	37 Single 1 Married	35 White 1 Asian 2 No Answer	9 Sophomore 21 Junior 8 Senior	38 Human Services	22 No 16 Yes
Solution-Focused Group	19-25	31 Female 4 Male	34 Single 1 Married	32 White 1 Asian 2 Hispanic	21 Sophomore 12 Junior 2 Senior	38 Human Services	24 No 11 Yes
Total Sample	19-35	67 Female 6 Male	71 Single 2 Married	67 White 2 Asian 2 Hispanic 2 No Answer	30 Sophomore 33 Junior 10 Senior	73 Human Services	46 No 27 Yes
Means and Percentages of Total Sample	20.4	92% Female 8% Male	97% Single 3% Married	91% White 3% Asian 3% Hispanic 3% No Answer	41% Sophomore 45% Junior 14% Senior	100% Human Services	63% No 37% Yes

Reliability of Instruments

Reliability was calculated through the use of Cronbach's alpha for the Counselor Rating Form – Short Version. Cronbach's alpha for the complete CRF-S was .94 (N=73). Cronbach's alpha for the attractiveness, expertness, and trustworthiness subscales of the CRF-S were .88, .92, and .87 respectively. These values are consistent with those found in previous studies,

where Cronbach's alpha ranged from .84-.92 for the attractiveness subscale, .84-.93 for the expertness subscale, and .79-.92 for the trustworthiness scale (Corrigan & Schmidt, 1983, Ellingson & Galassi, 1995; Tracey, Glidden, & Kokotovic, 1988; Ponterotto & Furlong, 1985).

In this study, scores on the total CRF-S ranged from 47-84 with a mean of 65.3. Scores on the attractiveness subscale ranged from 11-28 with a mean of 19.4. Scores on the expertness scale ranged from 13-28 with a mean of 23.1. Scores on the trustworthiness subscale ranged from 16-28 with a mean of 22.8. The midpoint on the total CRF-S is 48. The midpoint on each subscale is 16. Scores on the total CRF-S and the three subscales indicate that participants viewed the therapist as attractive, experienced, trustworthy, and overall, credible.

Group Comparisons

Demographic Information

T-tests and Chi-square tests were conducted in order to determine if significant demographic differences existed between groups. No significant differences were found between groups on the variable of age (mean for problem-focused = 20.7, mean for solution-focused = 20.1, t = .1.266, df = 71, p = .210). No significant differences were found between groups on the variable of gender (χ^2 = .918, df = 1, p = .338). No significant differences were found between groups on the variable of marital status (χ^2 = .003, df = 1, p = .953). No significant differences were found between groups on the variable of race (χ^2 = 1.120, df = 1, p = .290). No significant differences were found between groups on the variable of previous therapy (χ^2 = .891, df = 1, p = .345). Significant differences were found between groups on the variable of academic standing (χ^2 = 10.749, df = 2, p = .005). In the problem-focused group, the majority (55 percent) of the participants were Juniors, whereas in the solution-focused group, the majority (60 percent) were Sophomores (See Figures 4.1 and 4.2 for academic standing according to group).

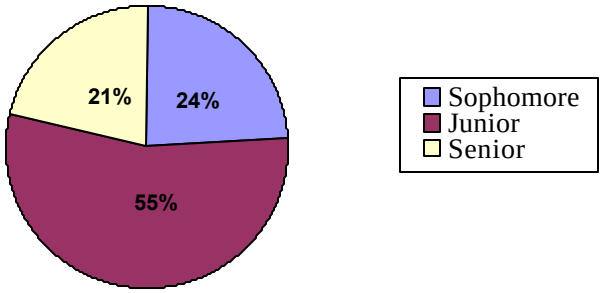

Figure 4.1. Academic Standing in the Problem-Focused Group

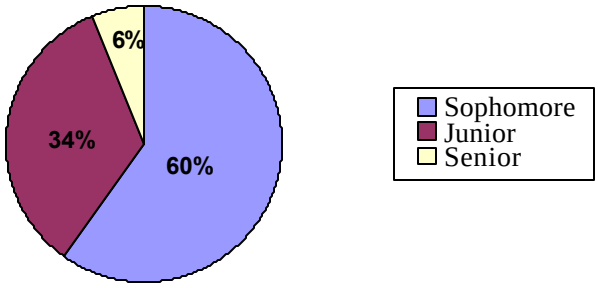

Figure 4.2. Academic Standing in the Solution-Focused Group

Counselor Rating Form – Short Version

T-tests were conducted on the total score and subscale scores on the CRF-S. On the total CRF-S scale, there were no significant differences between the groups (mean for problem-focused = 65.3, mean for solution-focused = 63.4, t = .748, df = 71, p = .457). On the attractiveness subscale of the CRF-S, there were no significant differences between the groups (mean for problem-focused = 19.5, mean for solution-focused = 19.8, t = -.341, df = 71, p = .734). On the expertness subscale of the CRF-S, there were no significant differences between the groups (mean for problem-focused = 23.0, mean for solution-focused = 22.4, t = .753 df = 71, p = .454). On the trustworthiness subscale of the CRF-S, there were no significant differences between the groups (mean for problem-focused = 22.8, mean for the solution-focused = 21.2, t = 1.732, df = 71, p = .088). On the likeliness that participants would seek out services from this

therapist, there were no significant differences between the groups (mean for problem-focused = 4.8, mean for solution-focused = 4.6, t = .639, df = 71, p = .525).

Qualitative Data

Qualitative data were collected through three questions. These questions were: (1) How likely would you go to this therapist? Please explain; (2) What did you like the most about this therapist?; and (3) What did you like the least about this therapist? Two participants did not answer the first question, one participant did not answer the second question, and three participants did not answer the third question. Data were entered first into a spreadsheet and then examined to determine categories of responses. Participants often gave more than one response to each question and these responses were coded separately.

Categories of Qualitative Data

Through the use of open coding, three categories were developed using the combined responses on all three qualitative questions. The categories are: (1) therapist characteristics; (2) actions/skills of therapist; and (3) other.

Therapist characteristics. This category consists of personal qualities of the therapist apart from specific therapeutic skills, and includes areas such as: dress, personality, respect, warmth, caring, empathy, sincerity, and tone of voice. Participants in this study cited the above areas in their responses. The following is an example of a response to the question about what the participant liked most about the therapist: "He seemed like he cared. He was very sincere and sensitive." The following is an example of a response to the question about what the participant liked least about the therapist: "He could have been a little more upbeat and not so monotone."

Actions and skills. This category includes areas such as: neutrality, knowledge, expertise, professionalism, nonverbal communication, reflection, comfort, interventions, homework, questions, understanding of the problem, and listening. Participants in this study cited the above areas in their responses. The following is an example of a response to the question about what the participant liked most about the therapist: "He understood the problem, gave the couple a

good homework assignment, and seems to know his job well." The following is an example of a response to the question about what the participant liked least about the therapist: "I would have gotten frustrated because I felt he asked some of the same questions over."

Other. This category includes all responses that did not fit into the above two categories of therapist characteristics and actions/skills of the therapist, and includes areas such as: therapeutic environment, session outcome, and therapist-client relationship. In the overall sample, only 11 responses were coded as "other" and these responses were dropped from subsequent analyses.

Likelihood Participants Would Seek Services from the Therapist

When asked to explain their rating on how likely they would be to seek out services from this therapist, 34 responses fell into the category of therapist characteristics and 56 responses fell into the category of actions and skills of the therapist. In the problem-focused group, 19 responses fell into the category of therapist characteristics and 31 responses fell into the category of actions and skills of the therapist. In the solution-focused group, 15 responses fell into the category of therapist characteristics and 25 responses fell into the category of actions and skills of the therapist (See Table 4.2). The distribution of responses by category between groups was not different ($\chi^2 = .0024$, df = 1, $p < .95$).

Table 4.2
Responses to the Explanations of their Ratings on How Likely Participants Were to Seek Services from the Therapist by Category

	Therapist Characteristics	Actions/Skills of Therapist
Problem-Focused Group	19	31
Solution-Focused Group	15	25
Total	34 (38%)	56 (62%)

Note. Some participants gave more than one response.

What Participants Liked Most

When asked to explain what they liked most about this therapist, 11 responses fell into the category of therapist characteristics and 66 responses fell into the category of actions and skills of the therapist. In the problem-focused group, three responses fell into the category of therapist characteristics and 38 responses fell into the category of actions and skills of the therapist. In the solution-focused group, eight responses fell into the category of therapist characteristics and 28 responses fell into the category of actions and skills of the therapist (See Table 4.3). The distribution of responses by category between groups was not different (χ^2 = 3.478, df = 1, p < .10).

Table 4.3
Responses to What Participants Liked Most About the Therapist by Category

	Therapist Characteristics	Actions/Skills of Therapist
Problem-Focused Group	3	38
Solution-Focused Group	8	28
Total	11 (14%)	66 (86%)

Note. Some participants gave more than one response.

What Participants Liked Least

When asked to explain what they liked least about this therapist, 47 responses fell into the category of therapist characteristics and 27 responses fell into the category of actions and skills of the therapist. In the problem-focused group, 28 responses fell into the category of therapist characteristics and 14 responses fell into the category of actions and skills of the therapist. In the solution-focused group, 19 responses fell into the category of therapist characteristics and 13 responses fell into the category of actions and skills of the therapist (See Table 4.4). The distribution of responses by category between groups was not different (χ^2 = .417, df = 1, p < .70).

Table 4.4
Responses to What Participants Liked Least About the Therapist by Category

	Therapist Characteristics	Actions/Skills of Therapist
Problem-Focused Group	28	14
Solution-Focused Group	19	13
Total	47 (64%)	27 (36%)

Note. Some participants gave more than one response.

Statistical Analyses of the Qualitative Data

Chi-square tests were conducted in order to determine: (1) if differences existed in the response categories between the problem-focused and the solution-focused groups in relation to what they liked most and least about the therapist and how likely they would be to seek out services from the therapist; and (2) if differences existed in response categories between what the participants liked most and least about the therapist.

No significant differences in which categories were used to describe the participants' responses were found between the problem-focused and solution-focused groups on their explanations for their ratings on how likely they would be to seek out services from the therapist ($\chi^2 = .0024$, df = 1, $p < .95$). No significant differences in which categories were used to explain the participants' responses were found between the problem-focused and solution-focused groups on what they liked most about the therapist ($\chi^2 = 3.478$, df = 1, $p < .10$). No significant differences in which categories were used to explain the participants' responses were found between the problem-focused and solution-focused groups on what they liked least about the therapist ($\chi^2 = .417$, df = 1, $p < .70$).

Significant differences were found between the two categories of therapist characteristics and actions/skills of the therapist and what participants liked most and least about the therapist ($\chi^2 = 38.655$, df = 1, $p < .001$). With regard to the explanations provided for their ratings on how likely they would be to seek services from this therapist, the majority of the participants' (62 percent) responses fell into the category of actions and skills of the therapist. With regard to what participants liked most about the therapist, the majority of the participants' (86 percent) responses fell into the category of actions and skills of the therapist. With regard to what participants liked least about the therapist, the majority of the participants' (64 percent)

responses fell into the category of therapist characteristics (See Figures 4.3 and 4.4 for response categories).

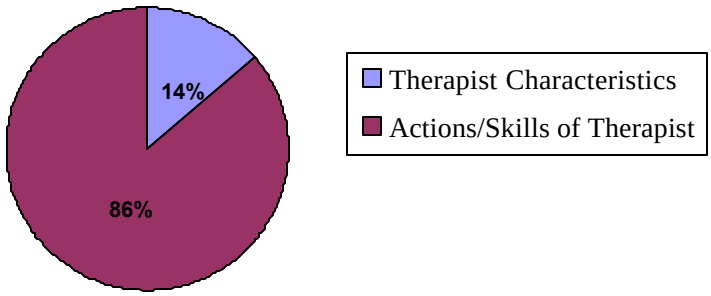

Figure 4.3. Response Categories of What Participants Liked Most About the Therapist

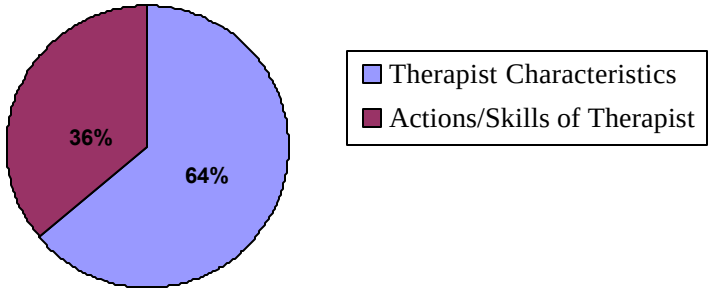

Figure 4.4. Response Categories of What Participants Liked Least About the Therapist

Summary

Hypothesis one was not confirmed. Therapist credibility, as measured by the CRF-S, did not differ significantly between the problem-focused and solution-focused groups. In addition, no significant differences were found between the groups on the subscales of the CRF-S (attractiveness, expertness, and trustworthiness). Finally, no significant differences were found

between the groups on the how likely the participants would be to seek out services from the therapist.

Three categories were discovered in the analysis of the qualitative data: (1) therapist characteristics; (2) actions/skills of therapist; and (3) other. With regard to the explanations provided for their ratings on how likely they would be to seek services from this therapist, the majority of the participants' (62 percent) responses fell into the category of actions and skills of the therapist, whereas 38 percent fell into the category of therapist characteristics. With regard to what participants liked most about the therapist, the majority of the participants' (86 percent) responses fell into the category of actions and skills of the therapist, whereas 14 percent fell into the category of therapist characteristics. With regard to what participants liked least about the therapist, the majority of the participants' (64 percent) responses fell into the category of therapist characteristics, whereas 36 percent fell into the category of actions and skills of the therapist.

No significant differences in which categories were used to explain the participants' responses were found between the problem-focused and solution-focused groups on their explanations for their ratings on how likely they would be to seek out services from the therapist. No significant differences in which categories were used to explain the participants' responses were found between the problem-focused and solution-focused groups on what they liked most and least about the therapist. Significant differences were found between the two categories of therapist characteristics and actions/skills of the therapist and what participants liked most and least about the therapist.

CHAPTER FIVE: DISCUSSION

Purpose of the Study

The purpose of this study is to investigate how potential clients perceive those therapists who use problem-focused and solution-focused language. Participants from two undergraduate classes at a southeastern state university were assigned to one of two groups: problem-focused and solution-focused. Participants viewed an eight-minute videotape of a role played therapy session either using problem-focused therapy or solution-focused language. This study is a posttest only quasi-experimental design.

First, the researcher investigated whether the mean scores on the Counselor Rating Form – Short Version differed by group. Second, the researcher examined the demographic information for the two groups and compared groups. Finally, the researcher coded qualitative data and compared the groups according to the responses given by question.

The research questions were: 1. Do potential clients perceive a therapist using solution-focused language as more attractive, experienced, trustworthy, and more credible than the same therapist using problem-focused language? 2. What other variables affect potential clients' view of the therapist?

Discussion of Results

Quantitative Results

In the current study, there were no significant differences between groups in counselor credibility as measured by the CRF-S. This is consistent with research that is available on the comparison of the level of counselor credibility between problem-focused and solution-focused therapy. Sundstrom (1993) found no significant differences on counselor credibility as a function of treatment condition. It was concluded that personal and professional characteristics of the counselors were important. The counselor's ability to form therapeutic relationships and convey empathy may be variables that explain the lack of perceived differences between the treatment conditions.

Literature comparing problem-focused and solution-focused therapy has produced mixed results. Speicher-Bocija (1999) found that clients in both session types (solution-focused and

problem-focused) found counseling to be a positive experience. Jordan and Quinn (1994) found no significant overall differences between the problem-focused and solution-focused approaches on measures of treatment adherence, working alliance, session evaluation, and outcome and expectancy. Littrell, Malia, and Vanderwood (1995) found that the three counseling approaches (problem-focused with a task, problem-focused without a task, and solution-focused with a task) did not differ in alleviating students' concerns. These researchers concluded that all three counseling approaches were successful in the movement towards goals. Sundstrom (1993) found no significant differences in the reduction of depressive symptoms between the problem-focused and solution-focused treatment groups.

One study found significant differences between problem-focused and solution-focused therapy. Adams, Piercy, and Jurich (1991) found that within the first two sessions of treatment, goal clarity and compliance were significantly higher in the two solution-focused approaches (solution-focused with task and solution-focused without task) than in the problem-focused approach with task. However, no significant differences were found between three approaches on treatment outcome.

The studies cited above provide evidence that significant differences in treatment outcome have not been found between problem-focused and solution-focused language. These results support the outcomes of the current research. In their discussion of the common factors that cut across all models of therapy, Miller, Duncan, & Hubble (1997) propose that particular therapeutic orientation or technique is not as important as the orientation's ability to help the therapist practice within the client's world view and expectations of treatment.

Qualitative Results

Results of the qualitative data found three categories of responses: (1) therapist characteristics; (2) actions/skills of the therapist; and (3) other. The first question asked participants to explain their rating on how likely they would be to seek out services from the therapist. The majority of the responses (62 percent) to this question fell into the category of actions/skills of the therapist, followed by therapist characteristics (38 percent). The second question asked participants to explain what they liked most about the therapist. The majority of the responses (86 percent) fell into the category of actions/skills of the therapist, followed by therapist characteristics (14 percent). The third question asked participants to explain what they

liked least about the therapist. The majority of the responses (64 percent) fell into the category of therapist characteristics, followed by actions/skill of the therapist (36 percent).

Post-hoc analysis found that participants used different criteria to account for what they liked most and least about the therapist. In explaining their rating on how likely they would be to seek out services from therapist, the majority of the participants' responses (62 percent) both positive and negative fell into the category of actions/skills of the therapist. In explaining what they liked most about the therapist, the majority of the participants' responses (86 percent) fell into the category of actions/skills of the therapist. In explaining what they liked least about the therapist, the majority of the participants' responses (64 percent) fell into the category of therapist characteristics.

These results indicate that participants use different criteria when analyzing what is desirable and not desirable about the therapist. It appears that the participants of this study use the expertise and knowledge of the therapist to describe what they found desirable, while they use the characteristics of the therapist to describe what they found less desirable.

Metcalf, Thomas, Duncan, Miller, and Hubble (1996) examined what clients and therapists found most helpful in the change process. Clients reported that the process of therapy is characterized by suggestions, pointing things out, and teaching. Therapists reported that the process is characterized by listening, collaborating, observing and reinforcing strengths, and not making suggestions. Speicher-Bocija (1999) also found that both groups (solution-focused and problem-focused) appreciated the therapist behaviors of understanding, support, assurance, provision of materials, offers of direct assistance, and input on behaviors.

Both the responses of the clients and therapists parallel the results in this study. According to the participants in the current study, important aspects of therapy include: therapist characteristics and actions/skills of the therapist. These two categories are similar to the categories suggested by Metcalf, Thomas, Duncan, Miller, and Hubble (1996) since they incorporate the following response areas: homework, interventions, questions, understanding the problem, listening, and neutrality.

Findings from the current study provide some support for the common factors model proposed by Miller, Duncan, and Hubble (1997). These authors suggest that there are four common factors that cut across all models of therapy. They state that the clients' perception of the therapist and what the therapist does determines the success of therapy. They also suggest

that therapists must listen empathetically to the clients' lives. Data from the current research shows that the type of language used did not influence participants' view of the therapist. However, participants in this study view the characteristics of the therapist and the actions/skills of the therapist as the most important aspects to how they view the counselor's credibility. The therapist's ability to listen to and provide empathy to the clients influenced the participants' perception of the therapist.

Limitations

There are some limitations to this study and careful interpretation of the results is necessary. One limitation is the sample that was used in the study. This sample is a homogeneous sample that contains mostly white, single, female, and young participants ages 19-35. This sample does not represent the general population and the results may only be representative of this particular population.

Another limitation is the way in which the two models of therapy were exemplified. Two videotapes were created to demonstrate the focus and language of these two models of therapy, however; they only were eight minutes in length. The videotapes gave participants only a partial view of complex models that require in depth explanation. With a broader picture of the models, differences in counselor credibility might arise.

Suggestions for Future Research

This research suggests that other factors beside the type of therapy model employed affect how potential clients view the credibility of the counselor. Further research is required in order to extend this understanding. In particular, research is needed in the area of the common factors and whether the variables of therapist characteristics and actions/skills of the therapist determine how potential clients rate the counselor's credibility.

Little research was found comparing problem-focused and solution-focused therapy, especially in the area of counselor credibility. Future research is needed to determine what clients find helpful in the therapeutic process. In addition, studies can focus on how clients perceive the common factors that cut across all models of therapy. Do clients perceive the therapist's understanding of the problem as more helpful than the type of therapeutic language used?

Further research is also warranted in the area of therapist gender. The gender of the therapist in this research may have influenced how the participants viewed the credibility of the counselor. Therefore, future studies could examine how the gender of the therapist influences the level of counselor credibility.

Even though significant differences were found between groups on academic standing, no differences were found on age. A possible explanation is that the even though the academic standing differed, it did not play a significant role in the results of the counselor credibility. However, more exploration of these variables needs to be conducted. Future studies could explore the relationship between counselor credibility and level of education.

Clinical Relevance

Researchers have attempted to examine what clients find helpful in therapy. This research has answered one more question in this search by suggesting that clients are not necessarily influenced by nuances in language. Therapist characteristics and actions/skills of the therapist appeared to contribute to what the participants liked most and least about the therapist. It appears that the ability for the therapist to understand a problem and to be empathetic contributes to how participants viewed the counselor's credibility. This provides evidence that potential clients focus less on the type of therapy used and more on the general components of therapy that cut across models.

This information is helpful to those clinicians who are attempting to find a right model of therapy. This is particularly useful to those clinicians in training who are trying to acquire skills that are considered helpful by their clients. According to the results, it is not as important to find the right model, as it is to convey empathy, understanding, and knowledge. Miller, Duncan, and Hubble (1997) suggest that "therapists spend less time trying to figure out the *right* intervention or practicing the *right* brand of therapy and spend more time doing what they do best: understanding, listening, building relationships, and encouraging clients to find ways to help themselves" (p. 30).

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APPENDIX A

Participant Informed Consent

Title of the Study: Potential Clients' View of Language in Therapy

Investigator: This study is being conducted by Stefani P. Hendrick, master's student in the Marriage and Family Therapy Program at Virginia Polytechnic Institute and State University.

I. Purpose of this Research

To determine potential clients' view of counselor attributes in respect to the therapist and client interaction.

II. Procedures

As a participant in this study, you will be asked to watch a videotape of an 8-minute role-play counseling session. Once you have viewed the tape, you will be asked to fill out the Counselor Rating Form - Short Form along with the Demographic Questionnaire. The entire process, viewing the videotape and filling out the questionnaires, should take no longer than 30 minutes.

III. Risks and Benefits of this Project

Since you are only asked to view a videotape of a role played therapy session, and to respond to the session by answering questions, there are no anticipated risks. By your participation in this study, you will provide the researcher with information regarding your perception of the therapeutic process. This research will help therapists to better understand the client's perception of therapy and what they feel is most helpful in the therapeutic process. If requested, results can be mailed to you.

IV. Anonymity and Confidentiality

Names will not be included on the questionnaires. Only information regarding your sex, age, education level, ethnicity, marital status, and previous mental health treatment will be collected. Names will only be written on the informed consent, which will be kept separate from the questionnaires. Information that is provided will be confidential. Only the researcher and her advisor will have access to the questionnaires. Upon completion of the study, all questionnaires will be destroyed.

V. Compensation

There is no compensation provided, except for our gratitude and appreciation for your participation. Results of this study will be provided to participants upon request.

VI. Freedom to Withdraw

If at any time you choose not to continue your participation in the study, you have the right to withdraw your consent. If at any time during the study you do not feel comfortable answering a certain question, you have the right to leave it blank.

VII. Approval of Research

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and by the Department of Human Development.

VIII. Participant's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:

- view an eight minute videotape
- complete research questionnaires

IX. Participant's Permission

I have read and understand the Informed Consent, which states the conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

If I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.

_____ _____

Participant's Signature Date

Should I have any questions about this research or its conduct, I may contact:

Stefani Hendrick (703) 538-8470
Investigator

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APPENDIX B

Demographic Questionnaire

Please answer the following questions. If you do not feel comfortable answering a specific question, you may leave it blank.

a) Age: _____

b) Gender: _____ Male _____ Female

c) Marital Status: _____ Single _____ Married _____ Divorced _____ Separated

d) Race: _____ Hispanic _____ Native American _____ African American

_____ Asian American _____ White, Non Hispanic

_____ Other (please specify)

5. What is your current academic standing?

_____ Freshman (0-30 credits) _____ Sophomore (30-60 credits)

_____ Junior (60-90 credits) _____ Senior (90-120 credits)

_____ Other (please specify) _____

6. What is your major? _____

7. Have you ever been in counseling or therapy? _____ Yes _____ No

APPENDIX C

Counselor Rating Form – Short Form (CRF-S)

We would like you to rate several characteristics of the therapist. For each characteristic on the following pages, there is a seven-point scale that ranges from "not very" to "very." Please mark and "X" at the point on the scale that best represents how you view the therapist. For example:

FUNNY

not very X : ___ : ___ : ___ : ___ : ___ : ___ : very

WELL DRESSED

not very ___ : ___ : ___ : ___ : ___ : X : ___ : very

These ratings might show that the therapist does not joke around much, but dresses nicely.

Though all of the following characteristics are desirable, therapists differ in their strengths. We are interested in knowing how you view these differences. Remember, your responses are totally anonymous. There is no way to associate you with the ratings you make.

After you have completed the ratings, please complete the background information requested on the last page.

Please rate the following characteristics according to the video that was observed:

FRIENDLY

not very ___ : ___ : ___ : ___ : ___ : ___ : ___ : very

EXPERIENCED

not very ___ : ___ : ___ : ___ : ___ : ___ : ___ : very

HONEST

not very ___ : ___ : ___ : ___ : ___ : ___ : ___ : very

LIKEABLE

not very ___ : ___ : ___ : ___ : ___ : ___ : ___ : very

EXPERT

not very ___ : ___ : ___ : ___ : ___ : ___ : ___ : very

RELIABLE

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

SOCIABLE

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

PREPARED

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

SINCERE

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

WARM

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

SKILLFUL

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

TRUSTWORTHY

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

How likely would you go to this therapist?

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ : very

Please explain: _____

_____

_____

What did you like the **most** about this therapist?

_____

_____

_____

What did you like the **least** about this therapist?

_____

_____

_____

APPENDIX D

Speech for Data Collection

My name is Stefani Hendrick and I am a third-year graduate student in Marriage and Family Therapy at the Falls Church campus of Virginia Tech. Currently, I am working on my thesis, one of my requirements for the MFT program.

I am researching how people view therapists in certain therapeutic situations. I am going to show you an 8-minute videotape of a role-played therapy session. Please pay attention to how you view the therapist and your opinions of him. The whole data collection will take no longer than 30 minutes. After completing the data collection, I will be happy to answer any questions in regards to details about the research.

(With the students who are left)
I want to thank you for agreeing to participate in my research.

I want to take just a few minutes to explain procedures for this research. This research requires you to watch a videotape of an 8-minute role-play therapy session. You will then be asked to fill out two questionnaires in response to this videotape. No names will be put on the questionnaires, therefore, ensuring your confidentiality. These questionnaires will only be seen by my thesis advisor and me and will be destroyed after the research is completed.

There is no compensation for your participation, except for my greatest gratitude. Since you are only answering questions regarding a role-play therapy session, there are no anticipated risks in your participation. You may withdraw at any time if you wish to not continue in the research. You may also leave any or all questions blank if you do not feel comfortable answering them.

This research has been approved by the IRB at Virginia Tech and the HD Department. If you wish to receive the results of this research, please contact me and I will be happy to provide them once the research has been completed.

First, I need you to review the Participant Informed Consent. When you have read it, please sign it and pass it to the front of the room. If you have any questions, please feel free to ask.

(After Informed Consents have been collected)
I will now show you a videotape of a role-play therapy session.

(After Video has been shown)
Please complete the Counselor Rating Form-Short Form and the Demographic Questionnaires that are being passed around. Remember that these questionnaires ask about your opinions of the therapist in this videotape. Once you completed the two questionnaires, please pass them to the front of the room. If you have any questions, please feel free to ask.

(After all questionnaires have been completed)
I want to thank you for your participation in my research.

APPENDIX E

Transcription – Solution-Focused Session

Voice over: **Susan and David have been married for four years and have one child, Lisa, age 2. Susan, age 25, works part-time as a substitute teacher. David, age 27, works full-time as a lawyer at a local law firm. They came to therapy because of marital conflicts. We now join them in their first session as they begin talking with their therapist about the problems they are experiencing.**

Therapist: It's nice to meet the two of you. Um, can you start out by telling me, telling me a little bit about what you would like to change? What's, what's brought you here?

Susan: Well, I asked David to come in here today because I don't believe that, um, things have been going well. Um, he's being working longer hours and hasn't been around the house as much and hasn't been helping out.

Therapist: Okay. So, one of your major concerns is that David hasn't been around as much and hasn't been helping out.

Susan: Right.

Therapist: Okay. David, what about from your perspective, what brought you two here today?

David: From my perspective, uh, I recognize, yeah, I am working a lot, but at the same time, that's my job.

Therapist: Uh huh.

David: I support the family financially.

Therapist: Uh huh.

David: And so I, I don't feel like I am getting much support, uh, for the fact that I have to do that and that's, I mean if I weren't working, we wouldn't have any money.

Therapist: Okay, so you feel like you're not getting support and Susan, it sounds like you feel kind of same way in some ways that you're not getting support and David's is gone a lot.

Susan: Well, you're right.

Therapist: Okay.

Susan: I do all of the childcare and all the house care, and housework. And that's pretty much right.

Therapist: Okay. Let me ask you, this is going to seem like an odd question, but it's a question that, um, we often times we forget to ask, but it's, it's a really important question, and that is often times when people call to make an appointment to come to therapy, they notice that between the time they make the appointment and the time they actually get here, sometimes they notice that some changes have already started to happen in their relationship. Have you guys noticed anything like that? *(Presession Change)*

Susan: Hmm, well to be honest, um, last week David actually brought me flowers.

Therapist: Wow.

Susan: Um, and he did it because he had been late five days in a row and I was mad. Um, and I appreciated the flowers, but I still was mad. He had been late all week.

Therapist: Uh huh. But, when David brought you the flowers it sounded, it sounds like for a minute, or for a little while anyway, that you weren't quite as mad as you have

been. So that was a little change. It doesn't take care of all of the problems, but it's a little change obviously.

Susan: Right, right.

Therapist: David, do you remember that?

David: Yeah, I mean that was something that I, boy, I can't remember the last time I brought flowers home. And so I, I was feeling like, you know, I had been coming home late, it was like five days in a row, kept coming home late. And I, I don't know, I just felt like that I should do that. And, and it did, I mean, that night, things felt better at home.

Therapist: Okay, so you noticed a change with Susan?

David: I did, yeah.

Therapist: Okay, that's interesting. Let me ask you, one of the things you'll find out is I have a number of odd questions, so let me ask you another kind of odd question to sort of get a picture of where we're going. Um, and this is one that people find kind of intriguing sometimes. Suppose tonight when you guys go home and go to bed, um, and you put your daughter to bed. You have a two year old, right?

Susan: Uh huh.

Therapist: You finally get your daughter to sleep, you go to bed, you go to sleep. And while you are sleeping, a miracle happens and the problems that brought you in here somehow are magically solved, okay. So you are asleep, the miracle happens, the problems are solved, but you two are asleep so you don't know that those problems have been solved. When you get up the next day, tomorrow, how would you know? What would be the things that would tell you that the problems that brought you here have been solved by the miracle? *(Miracle Question)*

Susan: Well, I think that when I woke up, uh, first David would be there.

Therapist: Okay.

Susan: And not at work already, um…

Therapist: Okay, so it isn't just in the evening, it's also in the. Okay, David would be there.

Susan: And we would eat breakfast together, um, with Lisa, with our daughter. Um, and we would actually have a nice breakfast together and eat and talk about the plans for his day and my day and what Lisa and I are were going to do and just be more involved.

Therapist: Okay.

Susan: Um, and clearly also that he would come home at a reasonable hour.

Therapist: Okay. Let me back up for a second Susan to breakfast, you, if I were watching your breakfast on videotape, what would I see that would tell me that this was a good time for you two, that it was meaningful for you?

Susan: Um, we would be enjoying each other's company.

Therapist: Okay.

Susan: Um, really communicating like we used to. Um, and, uh, just being happy and really enjoying ourselves and each other's company.

Therapist: Okay, alright. David, what, if that miracle happened tonight and you got up tomorrow morning, what would you see from your perspective?

David: I guess, yeah, assuming that I was still at home, um, which I think would be helpful.

Therapist: That would be part of it.

David: If there were a miracle, yeah, I would be home. That would be quite a miracle. *(laughs)* Um…

Therapist: So you two would wake up in the morning and there you'd be, right?

David: Yeah, yeah.

Therapist: Well, that's important, I think that's important.

David: Yeah, I think that, we would, I would be calm and we would have a conversation where we weren't bickering at each other. Um, I would be able to talk about what I had planned that day at work, um, without feeling like she was getting upset at me for having so many meetings or having to be at work, um, to, like I said, to support the family.

Therapist: Okay.

David: Uh, and I think also just a better relationship with, with my daughter would be a part of it too.

Therapist: So, you'd, there would be less bickering, more talking in the sense of really communicating, exchanging information, and so on.

David: Yeah.

Therapist: How would your relationship with Lisa look better, your daughter?

David: Well, I think just, I want to do more.

Therapist: Okay.

David: Um, usually Susan feeds her and does most of the care taking. I think I'd be a little bit more involved in that.

Therapist: Okay. So you might have feel that you have time to spend helping Lisa have breakfast or…you know

David: Yeah, maybe read her a story.

Therapist: Read her a story, or help her get dressed for the day or whatever.

David: Yeah.

Therapist: Okay.

Voice Over: Susan and David spent the rest of the session further discussing their marital disagreements. We now join them as they begin to end the session.

Therapist: Things that happens in therapy is we give homework assignments, so it's kind of like going back to school. And this is going to be an interesting, I hope it's an interesting homework assignment for you. Um, between now and the next time we meet, and we'll talk about another appointment time in a minute, but between now and the next time we meet, I'd like each of you to really pay attention and observe, so you that can come back and talk about it next time, what are the things that are going on in your relationship right now that you would really like to have continue, okay, or maybe even increase some? So what are the things, the activities, the feelings, things that are going on in your relationship that you'd like to have continue? *(Solution-Focused Formula First Session Task)* Is that clear?

S and D: Uh huh.

Therapist: Okay, good. Well, I'll see you, uh, in a week or so.

APPENDIX F

Transcription – Problem-Focused Session

Voice Over: **Susan and David have been married for four years and have one child, Lisa, age 2. Susan, age 25, works part-time as a substitute teacher. David, age 27, works full-time as a lawyer at a local law firm. They came to therapy because of marital conflicts. We now join them in their first session as they begin talking with their therapist about the problems they are experiencing.**

Therapist: Well, Susan, David, it's nice to meet you. Um, I'm glad you've come in today. Can you start by telling me a little bit about what, what brings you here, what problems you would like to work on?

Susan: Um, well, I asked David to come in here today because, um, I believe our marriage is in trouble. Um, he's…

Therapist: What do you mean by trouble Susan?

Susan: Um, well, um, he's been spending a lot more time at work and, um, we hardly ever talk anymore.

Therapist: Uh huh.

Susan: And I haven't been real happy with our relationship.

Therapist: Tell me, maybe this an odd question. How is that a problem, for, for you? Um, it seems obvious, but I want to understand from your perspective how it's a problem for you.

Susan: Um, well, I feel that he's not interested in my life and he's not interested in Lisa, um, our daughter's life.

Therapist: Okay.

Susan: Um, and I get angry that he's not here for us.

Therapist: Okay. So it's upsetting, it's an emotionally upsetting experience for you.

Susan: Yeah.

Therapist: Do you think David would agree that that's a problem? What's, what's your gut, we're going to ask him in a minute, but what's your guess?

Susan: David seems fine with this, um, I do all the housework and the childcare, um, he seems fine with this arrangement, the ways the things are going.

Therapist: Okay. So as near as you can tell, David doesn't see it as a problem?

Susan: Right.

Therapist: Okay. David, what about from your perspective, what brought you here today? What problems would you like to work on?

David: Well, I mean I do see our relationship, I mean I can tell we're not talking like we used to. But I guess I see the problem a little differently, uh, because I'm, I am working a lot, but the reason I am working a lot is because I am in charge of bringing home money for us, uh, to be able to live. And, and so I, I guess I see my not being at home as a way of supporting the family and not as something that's, uh, taking away from…

Therapist: Okay, so you see a problem too, it sounds like, but it's a little different problem than Susan sees? You see a problem with you guys not talking so much?

David: Yeah, we don't talk. I mean, I come home and it's instantly I'm being, you know, nagged at, yelled at, told all the things that I haven't done and should be doing. So yeah, I see that as the problem.

Therapist: Is coming home the time when his problem is, um, what, is there in the biggest form? I mean, is that when you see it the most, that coming home time?

Susan: Um, I would say so, yeah. It's a problem in the mornings too, you know he goes to work before I'm up. But um, but yeah, more of a problem at night. Yeah.

Therapist: Okay. Paint a little picture for me then. When David comes home, let's say, um, tonight you come home later than Susan is expecting you to. What's likely to happen? You walk in the door. I want to hear from both of you, how you see what's, what happens?

Susan: Um, well, I pout for a while.

Therapist: Okay.

Susan: And um, and then I get angry and I start yelling at him for being late.

Therapist: Okay. I don't want to embarrass you Susan, but what does pouting look like for you?

Susan: Um, being silent for a while. Maybe, um, slamming the things down a little harder than they need to be.

Therapist: Okay.

Susan: Um, just kind of letting the, you know, trying to let him know that I am upset that he's so late.

Therapist: Okay.

Susan: Um, but then it comes out, then you know, then I yell later.

Therapist: So there's a period of being silent and then there's a period of really letting it out.

Susan: Yeah.

Therapist: David, how about, how would you paint the picture? You come home, you walk in the door, you know you are late, I'm sure.

David: Uh huh, yeah, I agree with, with, what she said. She pouts and then she gets, gets upset. And so then, you know, I of course get upset too and uh, start yelling back and it, it just kind of goes from there until we kind of get to a point where we've yelled it all out and then kind of don't, don't want to talk anymore the whole night.

Therapist: Okay. Susan does that seem…

Susan: Yeah.

Therapist: Okay, let me make sure I've got a good picture of this then. So you come home late, Susan, you're, um, angry at that point. When David comes in, you don't say anything, but you kind of let your angry show in other ways, maybe, um, I don't know, when you're emptying the dishwasher, uh, dishes get put away in the cabinet kind of with some force or something like that.

Susan: Yeah.

Therapist: Okay. After a period of time, you kind of, um, feel like okay I need to really say something about this. You say something to David, it starts to get heated, David you answer her back in a heated way. It gets to a certain boiling point and then the two of you just sort of stop and back away. Is that pretty much what happens, am I getting an accurate picture.

David: Uh huh.

Susan: Yeah, I say that's pretty accurate.

Therapist: Okay. Can the two of you give me an idea of when these problems began that you have been talking about?

Susan: Um, well, David, um, got a big promotion and started working longer hours.

Therapist: Okay.

Susan: Um, and I'd say that was about a year ago.

Therapist: About a year ago.

Susan: And, um, ever since then, we, um, don't seem to talk as much and when we do talk it ends up in a disagreement.

Therapist: Okay.

Susan: Usually.

Therapist: Okay. So you'd say Susan about a year ago.

Susan: Yeah.

Therapist: The problems started.

Susan: Yeah.

Therapist: David, what's, what's, what's your thought?

David: I'd agree with that.

Therapist: About a year ago.

David: Yeah, I mean, that, that is when I started having to stay at work longer, going to work earlier.

Therapist: Okay.

David: Um, I guess if you were going to try to pinpoint a time, that's probably the best.

Therapist: Alright.

Voice Over: Susan and David spent the rest of the session further discussing their marital disagreements. We now join them as they begin to end the session.

Therapist: I want to assign, uh, you some homework and one of the things I should warn you about is in therapy we assign homework so it's kind of like going back to school. But this is the, what I'd like you to do. Between now and the next time we meet, and we'll plan our next meeting in a minute, it'll be about a week or so. Um, between now and the next time we meet I really want you two to watch closely so when you come back next time you can tell me these things, okay. What happens between the two of you when this problem next comes up, okay. So what's happening before the problem comes up, during the problem, you know the occurrence of the problem, and afterwards. So we can get a really, really clear picture of what both of you are doing, thinking, feeling when this problem occurs. *(Problem-Focused Formula First Session Task)* Is that clear?

S and D: Yeah.

Therapist: Okay, good. Well, then I'll count on seeing you in about a week and we'll, we'll talk about, um, the homework assignment.

Susan: Okay.

David: Alright.

VITA FOR STEFANI P. HENDRICK

ACADEMIC PREPARATION

Master of Science, Marriage and Family Therapy, Virginia Tech. Completed requirements for degree during May 2001. Acquired 61 graduate hours with a 3.88 G.P.A.; and 510 direct clinical hours serving families, couples and individuals. Completed clinical internship at the two following locations:

- Two-year clinical internship at the Center for Family Services, Virginia Tech, in Falls Church, Virginia.
- Eight-month internship with the Family Systems Counseling Unit, an entity of the Fairfax County Juvenile and Domestic Relations Court, in Fairfax, Virginia.

B.S. Family Studies 1997. University of Maryland, College Park, Maryland.

RELATED VOLUNTEER ACTIVITIES

Intern and Mentor, Rockville Youth Services, 1997

RELATED EDUCATION

Twelve hours of graduate credits in Marriage and Family Therapy, Hofstra University, 1997

RELATED WORK EXPERIENCE

Couples Group Facilitator/Anger Management Facilitator, Department of Human Development, Virginia Tech, Falls Church, VA, 1999-2001

Graduate Assistant, Information Technology Department, Virginia Tech, Falls Church, VA, 2000-2001

Relief Counselor, Alternative House/Kaleidoscope, McLean, VA, 1999-2000

Graduate Assistant, Federal Reimbursement Unit, Virginia Tech, Falls Church, VA, 1998-1999

Paralegal, Nicholas Campasano, Attorney at Law, Deer Park, NY, 1998