

**Solution-Focused Therapy and Communication Skills Training:  
An integrated approach to couples therapy**

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## **ABSTRACT**

This study uses a quasi-experimental design to determine if a solution-focused therapy (SFT) approach to couples counseling can be effective in improving an individual's marital satisfaction, and if a SFT approach to couples therapy can be improved upon by adding a one-time, psycho-educational intervention (i.e. Video #2 from the Fighting for your Marriage series: *The Speaker/Listener Technique*) that is normally not a part of the model.

Nine male-female couples participated in the project. One group (n = 8) completed treatment without viewing the communication skills video while the other group (n = 10) viewed the video at week two of treatment. Three questions were asked when analyzing data: 1. Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in marital satisfaction than individuals who receive solution-focus therapy only? 2. Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in satisfaction with their couple communication than those who receive solution-focused therapy only? 3. Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting more satisfaction with the therapy process than those who receive solution-focused therapy only?

No significant difference in marital satisfaction or communication satisfaction was found between the two groups. However, individuals who viewed the video reported being significantly more satisfied with therapy. In addition, both groups reported significant

improvement in their relationships which suggests that SFT promotes change. Evidence also suggests that males and females respond to SFT in significantly different ways.

The study was limited by its small sample size and one measure that was deemed unreliable. Findings suggest that integration of models and/or interventions is a delicate balance of art and design, and can be altered by such things as dose, philosophy, and placement of psychosocial treatments.

## **DEDICATION**

To Nancy Shands, your “BULL SHIT!” intervention continues to change me today.

To Rob McCann, thanks for putting up with all my bull shit.

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## CHAPTER ONE: INTRODUCTION

In June of 1999 I began an internship at the Chaplain's Family Life Ministry and Training Center at the Army's Fort Belvoir. As a part of the exchange for a placement and supervision, I was required to conduct no less than 50% of my therapy sessions according to a specific solution-focused therapy (SFT) approach. Having had prior experience with other treatment models, I often felt frustrated and confined by solution-focused therapy. On many occasions I felt I could be more helpful to my clients by abandoning SFT and addressing their concerns from a different perspective. As I gained more experience and familiarity with the model, I found I had less of a need to abandon it. However, I was still not convinced that a strict solution-focused approach was the most effective way of being helpful. There were times when rigidly adhering to the model seemed to run counter to its own edict; if what you are doing is not working, do something different. Exit surveys gathered by the Center seemed to agree somewhat with this assessment. They indicated that while many of the clients appreciated aspects of SFT, they also found value in some of the more direct interventions and psycho-educational tools employed by the therapist. Therefore, I began to question if an integrated or eclectic approach would be more effective than solution-focused therapy alone.

The times I felt most confined by SFT were when I was dealing with couples who were so angry with one another that they were unable to hear what the other was saying. These couples would often fight over minor details or be focused solely on their partner's need to change. The task of looking for exceptions, let alone identifying clear and well-defined goals, seemed next to impossible. I began to ask myself how these couples would ever get to a point where they were able to agree on even small things if they were unable to listen long enough to

hear what their partners had to say. Again, the Centers exit surveys provided a clue. While the survey collection was voluntary, informal, and focused primarily on the professionalism of the Center's staff, a few questions queried the client's satisfaction with the therapeutic experience as a whole. The center maintained an anecdotal record of clients' written responses to the question, "what part of the counseling worked best for you?" Of those who responded, 22 (32%) identified communications skills training as working best, and 11 (16%) specifically named the speaker/listener technique (as presented in *Fighting for Your Marriage*, Tape #2) as being most helpful. These responses led me to wonder if communications training could augment solution-focused couples' therapy.

### Statement of the Problem

The problem faced today by counselors and therapists, is the need to structure a practice in such a way as to secure payment for services from large managed health care providers, as well as provide meaningful and effective services to their clientele. Mental health practitioners are therefore forced to look for new and improved ways to be helpful and effective in a shorter period of time. The demands to decrease the length of treatment while maintaining (if not increasing) client satisfaction and positive outcome only serve to heighten the rush to improve upon brief therapeutic models.

Researchers and practitioners regularly report that new approaches and/or interventions better suit the needs of clients and have the potential to improve the effectiveness of treatment or decrease the number of necessary sessions. However, with only anecdotal evidence to support this notion, it appears that no one approach has seemed to have had as much an effect on the therapeutic community as solution-focused therapy. In recent years, journal articles and

seminars alike seem to focus more and more on approaches or interventions that are solution-focused in nature.

Though there is little evidence to prove the over-all effectiveness of solution-focused therapy (Lebow & Gurman, 1996), a few studies do point to its promise as an effective therapeutic approach (Kiser, 1988; Kiser & Nunnally, 1990; Sundstrom, 1993). Research with the solution-focused approach has not only identified the types of interventions found to be most useful to clients (Skidmore, 1993), it has attempted to identify the over-all effectiveness of specific solution-focused interventions (Adams, Piercy & Jurich, 1991; de Shazer 1985).

Yet, for many years research has shown that no one psychotherapeutic approach is significantly better than another (Luborsky, Singer, & Luborsky, 1975; Lambert & Bergin, 1994; Jacobson, 1985; Jacobson & Addis, 1993; Shadish et al., 1993). Additionally, Adams et al. (1991) concluded that no one intervention is able to have a significant impact on the over-all outcome of therapy. Therefore, a more recent trend in the field of solution-focused research is toward its integration with other therapeutic models (Bischof, 1993; Brasher, Campbell & Moen, 1993; Duncan, Solovey & Rusk, 1992; Eisenberg & Wahrman, 1991; Goldstein-Roca & Crisafulli, 1994; Miller, Duncan, & Hubble, 1997; Tuyn, 1993). This move toward a more integrative or eclectic practice is not unique to the area of solution-focused research, but to psychotherapeutic practice in general (Garfield & Bergin, 1994) as it seeks to meet the demands of the community.

Whitney Clark-Stager (1999) recently reported on an integration of solution-focused therapy, behavior marital therapy, and integrative behavioral couples therapy. Her findings were based on an individual case study from which she concluded, “that the combining of the theories is very beneficial in building on the inherent strengths of each model (p. 45).” She highlights the

benefits of combining models so that the strengths of one model can compensate for the weaknesses of the other. One issue she addresses is the fact that solution-focused therapy ignores the fact that some couples may lack the communication skills necessary to reach their own goals. This deficiency dovetails with behavioral marital therapy and its assumption that “distressed couples are often lacking in a variety of communication skills (Jacobson & Margolin, 1979, p. 190).” One of the goals of behavioral marital therapy is to teach couples the skills (both communications and problem-solving) they lack. Research indicates that distressed couples that have been taught the techniques used in behavioral marital therapy report an increase in marital satisfaction (Baucom & Epstein, 1990). By combining the two models one potentially enhances one with the other and thereby increasing the probability for a more positive out-come and greater marital satisfaction.

### Theoretical Framework

A postpositive approach has been selected to direct this study. This perspective affords the researcher the freedom to analyze the data with an unassuming, unbiased eye. Working from the mindset that research and science are not static, the findings are seen neither as right nor wrong, but as adding to the ever-growing pool of understanding. If one keeps in mind Denis Phillips’ (1990) statement that “theories come and theories go, new data accumulates, and old findings are interpreted in new ways (Phillips, 1990),” he/she is better equipped to view the findings for what they are without the pressure to make them something one hopes them to be. The postpositive belief that with time and understanding one can grow closer and closer to the truth (while not attaining it fully), allows those who take this position to view all findings as helpful in developing an understanding of what constitutes truth.

The postpositive approach partners well with the study of integrative models in that it does not hold that in order for one theory or model to be right another must be wrong. The belief that both may be part right or that both may be part wrong allows room to combine models in such a way as to assume that portions of both may be right and/or wrong at the same time. Data can therefore be interpreted solely on what is defined by the community at large.

### Purpose of the Study

This study uses a quasi-experimental design to determine if a solution-focused therapy (SFT) approach to couples counseling can be effective in improving an individual's marital satisfaction, and if a SFT approach to couples therapy can be improved upon by adding a one-time, psycho-educational intervention (i.e. Video #2 from the Fighting for your Marriage series: *The Speaker/Listener Technique*) that is normally not a part of the model. The questions to be answered by this study are as follows:

1. Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in marital satisfaction than individuals who receive solution-focus therapy only?
2. Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in satisfaction with their couple communication than those who receive solution-focused therapy only?
3. Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting more satisfaction with the therapy process than those who receive solution-focused therapy only?



## **CHAPTER TWO: LITERATURE REVIEW**

### **Introduction**

In this section I intend to give a brief over-view of the current literature in areas relating to this study. My intent is not to provide an exhaustive history of the origins of Solution-Focused Therapy (SFT) or of the nature of human communications, but to give some sense of how this study fills a gap in the present pool of research. My belief is that this research not only fills gaps in existing research, it attempts to implement research and assessment in such a way as to add to the understanding of more than one area at a time.

### **Solution-Focused Therapy**

Historically, brief therapy was thought of as problem-focused therapy or problem-solving therapy because of its focus on the resolution of the presenting problem(s) and/or any other problems that may arise during treatment. While still concerned with problem resolution, solution-focused therapy makes a notable shift from focusing on those behaviors that help to maintain the problem to those which help to alleviate it. In his early work, Steven de Shazer (1988), a leader in SFT, shifted the focus of brief therapy from the negative to the positive. His approach began to be more future-focused by encouraging greater solution-oriented talk as well as highlighting positive behaviors that support and facilitate change.

In the past, psychotherapy concerned itself with both problems and solutions, with the problem being the major point of focus. Although goals were mentioned and often well defined, the concentration of the time spent in treatment was on the identification and interpretation of the problem (de Shazer, 1988). However, with the onset of brief therapy, a shift began in how

therapy took place. The therapist's job became defining that problem which brought the client to treatment and developing a plan for creating change with regard to that specific problem.

Additionally, therapists began to develop treatment models, which sought to create change while maintaining the integrity of the client's social context (Jordan & Quinn, 1994). Therapists began to become more conscious of the client's words and language and use them as part of the treatment. Therapists started a shift in how they approached the client's issues by attempting not to assume their own understanding. Therefore, therapists began to step more into the world view of the client rather than to assume that they and the client share a similar world view.

de Shazer et al. (1986) began to define the focus of brief therapy as using what the client brought with them to therapy in order to help them create satisfactory lives for themselves. The focus of therapy became problem resolution, rather than identification, and goal achievement as it pertained to the client's own life (Jordan & Quinn, 1994).

Molnar and de Shazer (1987) began to suggest that the focus of therapy should be on the solutions to problems rather than the problems themselves. de Shazer's (1988) shift from negative (the problem) to positive (the solution) facilitated change by keeping the focus of the therapeutic discussion on the ways to solve the problem rather than on the problem itself. His more solution-oriented talk concentrated on the client's own strengths and abilities and thus created a transition toward a more solution-focused way of thinking.

Solution-focused therapy became a behavioral based treatment model that has its roots in the work of Milton Erickson (Bischof, 1993; de Shazer, 1985). de Shazer built upon Erickson's use of client strengths and resources to develop a therapeutic approach that is driven primarily by the client's vision for their own lives. Erickson's ability to explore both the client's past and present for exceptions to problem behavior has become a foundational aspect of de Shazer's

work (Bischof, 1993). The solution-focused approach depends upon the client's ability to identify their own problems and create their own solutions. By discussing ways the client has managed problems in the past, the therapist is able to work collaboratively with the client to identify ways of applying what has worked in the past to the present situation.

Michael Hjerth (1995) outlines three basic components of solution-focused therapy: philosophy (basic premises and assumptions), use of language, and techniques. SFT assumes three basic facts; change is constant, the client has the resources to elicit change, and there are exceptions to all types of behavior. These assumptions are a driving force and must be accepted if the model is to work. The therapist uses them to help the client identify times when they have experienced bits of their own desired vision and then assists them in working to recreate that experience on a more regular basis. Both therapist and client work together to notice change, no matter how small, in order to shift the focus from the problem to its solution. This shift in perspective from negative to positive is managed through the language of SFT. The language assumes possibility and is future-oriented. Its goal is to create cooperation by putting the client in control of the change process. "This language creates a stance of cooperation on the part of the therapist, who tries to agree with her clients and is always alert to their use of language and to their changing goals during the process of therapy. This stance includes also an attempt to stay 'behind' the client, to carefully listen to them and to avoid pushing them in the therapist's direction. The therapist does not lecture to the clients or tell them what to do, but tries to help them figure out on their own what course of action to follow (Beyebach & Morejon, 1999, p. 29)." Solution-focused language is also future-focused. Clients are encouraged to think about what they would like to have change, and what they could do to create that change. "When you are no longer doing that, what will you be doing instead?" and "What would you have to do to

make that happen?” are typical solution-focused questions. The client is encouraged to think of themselves as having already reached their desired goal and then asked to look back at what they would have had to do to get there. By doing so, the client takes charge of their own life and develops a treatment plan for their own therapy.

This form of language contrasts sharply with a more problem-focused model in which clients are asked to identify what they may have done to create and maintain the problem. The problem-focused approach assumes the solution to a problem is hidden within the problem itself. The idea is that by gaining a better understanding of the problem, one will have a better understanding of how it may be solved. The solution-focused model does not make this same assumption. By shifting the focus of the discussion away from the problem and toward the solution, both the client and the therapist are free to identify solutions that may otherwise be seen as unrelated. Here again, this task is accomplished through the language of SFT. Clients often see the onus of change as being on another individual. Yet, when they are encouraged to think of times when things have been more as they hope them to be, they are able to see that by their own changed behavior they were able to manage the situation.

SFT techniques include creating a vision of change, identifying exceptions to the undesirable behavior, assessing progress and confidence through scaling questions, and practicing change in order to identify what works. All of these techniques, while common to the model, are not necessary for its success. The therapist’s job is to work with the client to identify and intensify behaviors that produce the desired result.

Despite its theoretical rationale and clinical appeal, there is little evidence to support the argument that SFT is an effective therapeutic approach (Lebow & Gurman, 1996), although, a few studies do point to its promise (Kiser, 1988; Kiser & Nunnally, 1990; Sundstrom, 1993).

Research with SFT has identified the types of interventions found to be most useful to clients (Skidmore, 1993); it has also attempted to identify the over-all effectiveness of specific solution-focused interventions (Adams, Piercy & Jurich, 1991; de Shazer 1985). Few outcome studies exist for the solution-focused model of brief therapy.

One of the first outcome studies of SFT (Burr, 1993) used a follow-up design to assess the long-term effectiveness of SFT with clients who were referred to therapy by general practitioners and colleagues in the mental health services. The study reported a good outcome in 62% of the cases responding to the follow-up survey. These findings were further validated by two similar studies conducted by the same treatment center (Macdonald, 1994 & 1997). In these studies a good outcome was defined as “either that attenders themselves reported that the problem was better, or that the general practitioner reported that the problem was better if information from the attenders was not available (Macdonald, 1997, p. 215).” Macdonald (1997) went on to conclude that SFT not only helped clients resolve their presenting problems, but seemed to enhance their ability to deal with a range of other matters. Other researchers have conducted follow-up studies and reported findings indicating the over-all effectiveness of SFT (Kiser & Nunnally, 1990; DeJong, P., Hopewood, L., 1996; Lee, M., 1997; DeJong & Berg, 1998; Isebaert, L. & Vuysse, S., in preparation).

In a pilot study conducted by Triantafillou (1997) designed to assess the effectiveness of a solution-focused approach to mental health supervision, the researcher concluded that “treatment effects indicate that solution-focused supervision can lead to reduction in the frequency of client episodes of aggressive and anti-social behavior, as well as to reductions in the use of psychotropic medication to control these episodes (p. 321).”

Another study (Zimmerman, Jacobsen, MacIntyre, and Watson, 1996) used data derived from an experimental research project designed to test the theoretical assertion that participation in a solution-focused parenting group is an effective intervention strategy for parental management of common adolescent problem behavior. Pre and post-test data was gathered and analyzed for both a control and experimental group. The findings suggested that parents who participated in the solution-focused parenting group “felt more secure and confident with their parental image... became more skilled in openness and directness, which resulted in increased positive adolescent response...limit setting...[and] that parents, overall, felt more skilled in the area of parenting after the six-week group experiment (p. 23).” This study was, however, limited in its unequal samples size (control group n = 12, experimental group n = 30).

Other studies have examined the effectiveness of SFT with a variety of client problems (DeJong & Berg, 1998), with different client populations (de Shazer & Isebaert, 1997; Eakes, Walsh, Markowski, Cain, & Swanson, 1997), and in a variety of settings (LaFountain, Garner, & Eliason, 1996; Zimmerman, Jacobson, MacIntyre, & Watson, 1996; Cockburn, Thomas, & Cockburn, 1997; Lindfors & Magnusson, 1997; Schorr, 1997; Zimmermann, Prest, & Wetzel, 1997). Varying results have been produced by studies with SFT.

DeJong and Berg (1998) reported that SFT produced a 70% or better success rate when addressing a variety of client problems. de Shazer and Isebaert (1997) conducted studies with clients dealing with alcohol problems as either inpatients or outpatients, and reported a success rate of greater than 73% for both groups. LaFountain, et al. (1996) conducted a study which assessed the effectiveness of SFT by comparing the outcome of standard counseling groups for elementary and high school students with groups conducted by counselors who had been newly trained in solution-focused brief therapy. The results of the study indicated a significant

difference between groups on 3 of 8 measures. Counselors in the experimental group reported that 81% of their clients had achieved their goals. These counselors also reported feeling less exhausted and having fewer feelings of depersonalization at the end of one year than did counselors in the control group. This study suggests that SFT is not only helpful to the client, but to the therapist also. Cockburn, et al. (1997) applied SFT techniques to orthopedic rehabilitation and found significant difference in several areas as compared to patients who received standard rehabilitation. A sixty-day follow-up on patients in this study found those who received SFT/rehabilitation returned to work more readily than did those who did not.

On the other hand, Sundstrom (1993) compared the effectiveness of a single session of SFT with one that was more problem-focused and reported no significant difference between groups. Littrell, et al. (1995) conducted a study with high schools students which also compared SFT with problem-focused therapy and reported similar results. In a study by Sundman (1997) where SFT was applied to a social services setting, a one-year follow-up indicated no difference in goal attainment between experimental and control groups.

Researchers have attempted to determine the effect SFT has on the number of sessions required before termination. Findings range from an average of 2.9 sessions (De Jong & Berg, 1998) to 5.5 sessions (Lee, 1997). Some studies have even sought to compare the effectiveness of SFT to that of other treatment models (Littrell, Malia, & Vanderwood, 1995; Cockburn, Thomas, & Cockburn, 1997; Lindforss & Magnusson, 1997).

Together these studies are not conclusive in their assertion of the over-all effectiveness of the SFT model. While results from a number of studies have suggested that SFT is an effective treatment model and may even be more effective than other models, the findings are somewhat questionable due to poor experimental design, small sample size, incongruent size of

experimental and control groups, and lack of generalizability. Regardless, there is enough evidence in research conducted thus far with SFT to give credence to the effectiveness of the model and the need for additional study.

### Criticism of the model

Criticism has focused on the validity of SFT's assumptions. Critics have challenged the simplicity of the solution-focused model (Wylie, 1990) and questioned the potential limits the more positive focus places on the client's ability to fully explore the issues which brought them to therapy (Efran & Schenker, 1993). There is some belief that by focusing primarily on what is going well, the therapist runs the risk of invalidating the more negative feelings the client may be having. Clients who experience invalidation as a part of their own problem may see therapy as more of the same. Thus, reinforcing their already dysfunctional system. SFT's sometimes-strict adherence to such formulations may not fit the needs of every client (Nichols & Schwarz, 1995). The therapist assumes the client has the capabilities to create the change necessary to reach their own vision. However, the fact that the client may not know how to create the change or have the necessary capabilities to do so is seldom, if ever, considered. "Another argument is that SFT ignores the fact that some clients may not have the skills necessary to achieve their goals. For instance, in some situations, it may be necessary to teach clients new ways of interacting or communicating (Clark-Stager, 1999, p.36)."

### **Communications research**

Surveys indicate that communication problems are the most frequently cited reason for relationship difficulties (e.g., Cunningham, Braiker, & Kelly, 1982), and are the most common



complaint of couples entering therapy (Geiss & O’Leary, 1981; Hahlweg, Revenstorf, & Schindler, 1984). Historically, it was assumed that conflict in relationships exists or was complicated by a lack of communications skill on the part of either or both partners (e.g., Burger & Jacobson, 1979; Cahn, 1990; Markman & Floyd, 1980). Jacobson and Christensen (1996) state that the mastery of communications and problem-solving skills benefit couples in the long run by enabling them to apply what they have learned to other areas. They believe that couples, by mastering their communication and problem-solving skills, can be their own therapist when faced with other, similar problems in the future. Communication training has become an important component in many approaches to marital therapy (O’Donohue & Crouch, 1996). Behavioral Marital Therapy (BMT), which is the most researched clinical intervention for the treatment of marital distress (Shadish et al., 1993), assumes that “distressed couples are often lacking in a variety of communication skills (Jacobson & Margolin, 1979, p. 190).” Research on marital conflict often assumes this skill deficit model (e.g., Halford, Hahlweg, & Dunne, 1990; O’Donohue & Crouch, 1996; Noller, 1993; Sillars & Weisberg, 1987). Paul James (1991) found in his study, which combined Emotionally Focused Therapy with Communications Training, that couples experienced “superior immediate gains in communication than couples who are not in therapy if the therapeutic approach uses, and specifically targets, communication as an area of change (p.272).” However, in later follow-up sessions those couples that had previously shown significant gains by receiving communications training showed greater regression than couples that had not. These findings seem to coincide with other research findings. “Many of the interventions that are focused on developing communication skills have proven to be less than effective and lasting methods of enhancing marital satisfaction and eliminating undesirable behaviors...A careful review of the relevant literature reveals that the impact of communication

skills on marital satisfaction has been assumed much more frequently than it has been shown (Burleson & Denton, 1997, p.885-886).” Proponents of BMT have gone so far as to move to reduce the focus on communications skill training, in response to increased dissatisfaction with its ability to improve dyadic satisfaction (Cordova & Jacobson, 1993).

### PREP, Inc.

The PREP program is a cognitive-behavioral approach to couples therapy that teaches “very specific, very structured models of effective communication and problem solving (Stanley et al., 1999).” The goal of the PREP program is to increase a couple’s relationship satisfaction and future success by reducing and/or eliminating negative behaviors that are identified as predictors for relationship dissatisfaction. Structured interventions such as the speaker/listener technique are designed to “help couples learn how to counteract the negative patterns of interaction that can bring a marriage to its knees. In fact, following the rules of the technique virtually guarantees that certain negative patterns will not be expressed (Stanley et al., 1999).” In a number of long term studies which compared PREP to matched control couples (Markman et al., 1993; Stanley et al., 1995; Markman, Floyd, Stanley, & Storaasli, 1998), PREP couples demonstrated greater relationship satisfaction than control couples up to five years following training. When assessed repeatedly over years after their training, PREP couples showed better communication skills than did control couples. PREP couples display greater positive affect, increased problem-solving skills and more frequent support/validation behaviors while communication with their partners than did controls. Out-come studies designed to assess the effectiveness of the PREP program have found that couples who are trained are significantly more satisfied and stable at the 3 year follow-up when compared to controls (Thurmaier et al.,

1993). Studies conducted by the developers of the PREP program (Markman, Renick, Floyd, Stanley and Clements, 1993; Hahlweg, Markman, Thurmaier, Engl and Eckert, 1998) compared the program to both control groups of couples who declined to participate in the program and couples who participated in other similar programs. Findings in these studies were similar to those previously mentioned.

The PREP program seeks to help couples develop a well-defined structure within which to communicate. Their belief is that for couples to communicate effectively during times of conflict and/or anxiety, they must develop tools which allow them to adjust the amount of structure governing the communication in such a way as to manage the intensity of the conversation. The idea is that the “hotter” the issue, the greater the structure required to keep the situation under control.

The Speaker-Listener Technique is one of the tools employed by the PREP program to maximize couple communication and minimize invalidating forms of behavior. The technique employs active listening skills, such as paraphrasing, in order to reduce a couple’s tendency toward escalation, invalidation, negative interpretation, and withdrawal during times of stress or conflict. Couples use an object to indicate who has “the floor,” thereby differentiating between who is the “speaker” and who is the “listener”. Clear rules are defined regarding the behavior of both positions during conversation. (See figure 2.1) The PREP philosophy is that in order for a couple to come to agreement on an issue they must first have an understanding of each partner’s perception. Couples are reminded that validating the partner’s opinion is different from agreeing.

Figure 2.1



The Speaker-Listener Technique is one of several tools used by PREP to help couples better manage disagreement. While to some, the structure employed by the program may appear too artificial or confining, it is designed to help couples understand the benefits of having clearly defined boundaries for interaction that, if missing, may open up the conversation for unpleasant, unproductive, and potential destructive behavior.

The video used for this study is one of a four part series designed to help couples manage conflict and improve their marital satisfaction. Each video presents a different aspect of the PREP approach. The videos combine live, unrehearsed interviews and footage of couples in the process of learning the different techniques with narrative and explanation from professionals experienced with the PREP approach. Individuals viewing the tape are instructed on what the techniques are and what they are designed to do. Viewers are then shown segments of sessions with couples at different stages of the learning process. In the video viewed for this study, couples are shown engaging in discussions/disagreements both with and without the use of the speaker/listener technique. The narrator reminds the viewer of the ground rules for

communication learned in video one and introduces the speaker/listener technique and its intent to create an atmosphere of validation and understanding as a vital part of conflict resolution. Viewers are reminded that coming to agreement is not the intent of the speaker/listener technique, but is better achieved once understanding can be established.

## **Integration**

### Recent trends

The integration of models is not new to the therapeutic community. Researchers and practicing clinicians have combined theoretical approaches and interventions in innovative and necessary ways for years. In their attempt to develop treatment plans and models that are more helpful to clients, therapists and researcher often combine what they believe to be the best parts of different approaches. Integration can be either by design or an act of therapeutic desperation. Regardless of its origin, the goal remains the same: to facilitate change. Researchers develop new and improved treatment plans by combining what is believed to be the best parts of existing plans/models. Therapists often integrate approaches and interventions into eclectic modes of treatment as they seek to meet the specific needs of their individual clients.

When evaluating work conducted in the field of integration, one is able to identify two major categories: theoretical integration and technical integration. Beyebach and Morejon (1999) define theoretical integration as that which combines two or more psychotherapy models in such a way that what is produced is different and more complex. They describe technical integration as importing and exporting specific therapeutic techniques, procedures, and interventions from one therapeutic approach to another. Both methods of integration encounter difficulty in combining techniques and approaches that may have very different premises. The

skill and wisdom to know what works and what does not is often acquired through a difficult process of trial and error. Researchers often base their work upon anecdotal evidence they have gathered either from their own work as therapist or from the stories of others. Therapists who see clients on a daily basis are sometimes forced to pull from many models within a given session. It is through this necessary process of trial and error that all effective therapists learn what works best for their clients.

### Solution-Focused Therapy and Integration

The trend toward integrative (and eclectic) practice is apparent not only in the field of solution-focused therapy, but also in the world of psychotherapy in general (Garfield & Bergin, 1994). For instance, in their recent review on the state of the art of family and marital therapy, Lebow and Gruman (1996) noted how the better tested treatments tend to be integrative packages, and even stated that “one-dimensional, one-size-fits-all therapy is the wave of the past (p. 72).” However, when considering integrating any model with SFT, one is faced with a difficult dilemma. “There are no well-researched Solution-Focused practices that provide a sound ground for integration (Beyebach & Morejon, 1999, p.25).” While apparently popular with the therapeutic community, SFT is not highly researched. This fact makes integration a complicated process. When only anecdotal evidence exists to indicate the approach’s effectiveness, it is risky to pull out pieces of the model and identify them as that which makes the model effective. To go the next step and combine those pieces with portions of another model neither supports the effectiveness of the part or the whole.

Beyebach and Morejon (1999) identify an even more difficult obstacle to address when considering integrating any model with SFT. They point out the fact that SFT requires the

therapist to take a position of non-expert, and that by deciding to integrate the therapist shifts that therapeutic posture. They believe that the very act of integrating places the therapist in a position of following his/her own ideas about the therapeutic process rather than taking the lead from the client. By doing this, the therapist is no longer behaving in a solution-focused manner. This is an important consideration when conducting this kind of integration. One is required to consider if the approaches are compatible, when and how to make an effective shift if they are not.

### **Summary**

One of the more difficult tasks in this research is to integrate two treatment methods that are nearly diametrically opposed. Communications training implies that the therapist (or teacher) has some greater knowledge than the client (or student), while Solution-Focused Therapy requires the therapist to take a “not-knowing” stance. In the end, this study adds to the pool of knowledge in many ways. The questions being asked add to the understanding of what works for clients by assessing the effectiveness of both Solution-Focused Therapy and communications skill training, as well as our understanding of when, how and why to integrate treatment models and interventions.

## CHAPTER THREE: METHODS

### The Center

The Chaplain's Family Life Center is a unit of the Chaplain's Office, which provides individual, couple and family therapy to military service members. The Center is located on a large military post in the Washington, D.C. metropolitan area. While services are provided to all branches of the military, the clientele at the Center is primarily Army. Both active duty and retired service members are eligible to receive services at the Center. Therapy services are also provided to spouses and dependents who hold valid military identification cards.

The Center is supervised by an active duty Army Chaplain who has been trained as a Family Therapy Chaplain. The staff consists of interns who volunteer their services in trade for clinical hours and supervision. Interns are required to have had no less than one year of supervised training prior to coming to the Center. All of the interns who participated in this study were completing their final hours toward a Masters of Science in marriage and family therapy.

Approximately two years prior to this study, the Center began to use Solution-Focused Therapy as its primary therapeutic approach. All of the therapists and interns were required to conduct at least fifty percent of their caseload in a solution-focused format. Training was provided for all staff by such leading professionals in the field of Solution-Focused Therapy as Insoo Kim Berg. Supervision for the interns was conducted in such a way as to model the method to be used in the therapy room. Interns were often asked such questions as; "What needs to happen today for you to feel like supervision was helpful?" and "Tell me about a time when you felt like you were more helpful to your clients. What was different about you during that



session?” Therapists were required to follow a set format for conducting a solution-focused session. (See appendix B) Because the staff at the Center were trained and familiar with the use of the solution-focused model, it was identified as an ideal location for this study.

### The Subjects

Participants in this study were self-referred, heterosexual, couples from the Army’s Chaplain’s Family Life Ministry and Training Center located at Fort Belvoir, Virginia. All the couples participating in the study did so on a voluntary basis. Couples who participated were required to be either married or to have lived together for at least two years prior to participation in the study. No other criteria were used to select couples for participation in this study. The limited participation criteria was designed to produce as large a sample as possible, as well as to sample a population more typical of a standard out-patient practice. All of the participants in the study presented as couples seeking couple or marital therapy. Additionally, all couples identified marital enrichment and improved communication as part of their therapeutic goals.

Twenty couples participated in this study. Nine couples completed the eight weeks of therapy, four are currently receiving services, and seven either dropped out or terminated before completing post-test data collection. Five of the couples not completing the program discontinued therapy prior to their fourth session and were considered drop-outs. The other two couples discontinued after their fourth session with one or both partners reporting progress toward their desired goal as an eight or above on a scale of 1-10 (10 being they had reached their goal and were ready to end therapy). These couples terminated by phone and were considered to have terminated prior to data collection rather than to drop-out.

While there was no significant difference on the DAS scores of individuals who completed compared to those who dropped out, the individuals who dropped out did have a mean DAS score of 76.90 versus a mean of 85.06 for those who did not. Spanier (1976) defines distressed couples as those who have at least one partner with a DAS score below 100. He goes on to define severely distressed couples as those who have at least one partner with a score below 70. Three of the five couples who were defined as drop-outs had at least one partner with a total DAS score of less than 50. Only one of the couples that completed began with a partner having a DAS of less than 50. The one couple that completed the eight weeks of treatment continued beyond the scope of this study and were the only known couple electing to divorce.

The average age of the males completing the study was 36 and for females it was 32. Participating couples that completed the eight weeks of therapy had relationships ranging from pre-marital to twenty years of marriage. The average length of marriages was 8 years. One couple entered the program prior to getting married, but married prior to completion. Thirteen participants identified themselves as Caucasian, 2 African-American, and 3 Hispanic. Seven of the completing couples were Army, one Air Force, and one Navy. Two of the participants were officers while the remainder was enlisted.

### Procedure

Prior to their initial session, all clients at the Family Life Center are required to complete a series of intake forms. All couples that completed the intake forms were asked to participate in the research. (See figure 3.1). Those who indicated a willingness to participate were asked to review and sign the additional research forms: including an outline of the research goals and requirements, informed consent (See appendix A), the Dyadic Adjustment Scale (DAS), Kansas

Marital Satisfaction (KMS) Scale, and the ENRICH Communication Scale (ECS). Those interested in participating in the study, but who were unable to complete the forms at intake were asked to review and sign all research forms at home and return them to their therapist upon attending their first scheduled therapy session.

Once the initial intake forms were completed, participating couples were randomly assigned to one of two research groups. Group A received eight weeks of Solution-Focused Therapy and viewed the Speaker/Listener tape as part of their second session. Group B received eight weeks of Solution-Focused Therapy without viewing the Speaker/Listener tape or being instructed in the technique. Assignment to groups was alternated based upon the date of intake. The first couple agreeing to participate in the study was assigned to group A, the second assigned to group B, etc. Assignment to groups continued in this fashion throughout the duration of the study.

The introduction of the videotape as a part of treatment differed from case to case. Because all of the couples involved indicated poor communication as part of the presenting problem and its improvement as part of the solution, most of the couples were informed at the end of the first session that they would be viewing a communication training video during the subsequent session. Those couples who had not been given prior notification of the video were advised by the therapist that because they had indicated communication as an issue in their marriage, it was thought that viewing the video might be helpful in setting the stage for improvement. All couples were encouraged to focus on the technique being presented not the issues the couples were discussing.

Couples participating in the study were asked to attend treatment for a minimum of eight weeks. If a couple elected to terminate treatment prior to the eighth week, they were asked to

complete the DAS, KMS, ECS, and the Client Satisfaction Questionnaire (CSQ-8) after their final session. Data collected from couples terminating early were analyzed along with other data. However, a special note was made to indicate that these couples terminated early. Data collected from couples who dropped out or terminated prior to completing the final closure materials were not included in the data for analysis.

Participating couples were initially assigned to one of three therapists, each of whom had varying degrees of training and experience working with the SFT model. Couples were assigned to a therapist based solely on the therapist's availability. The therapists were given no control over which group their couples were assigned to. Therefore, all of the participating therapists provided services for a varying number of couples from each group. All sessions were video taped as required by the Family Life Center. Each participating therapist received individual supervision from the Center director. The Center's director was fully trained in the SFT model and was familiar with the use of the speaker/listener technique.

Changes in procedure were required shortly after the implementation of the study due to changes in staffing at the Center. The major portion of the study was conducted with the researcher as the sole therapist for all of the couples involved. Attempts were made to conceal the identity of the researcher from the participants in hopes to limit any impact this knowledge would have on the study's outcome. The assignment of couples to A and B groups remained the same as did all other procedural matters.

Therapy sessions were fifty minutes long. The therapists participating in the study were required to follow a specific structure when conducting the therapy session. (See appendix B) While the design of the session was specific, therapists were allowed the freedom to work at their own pace and according to their own style. A rigid adherence to a formulaic session was

not required as long as the therapist maintained a solution-focused frame with in which they worked. At the end of each session, clients completed the KMS and were asked to answer two additional scaling questions regarding progress and helpfulness of the session.

At the end of the eight weeks, or at termination, whichever came first, all clients completed the DAS, KMS, ECS, and the CSQ-8. All couples participating in the study were given the opportunity to continue in treatment beyond the eight weeks of research.

# Treatment Plan

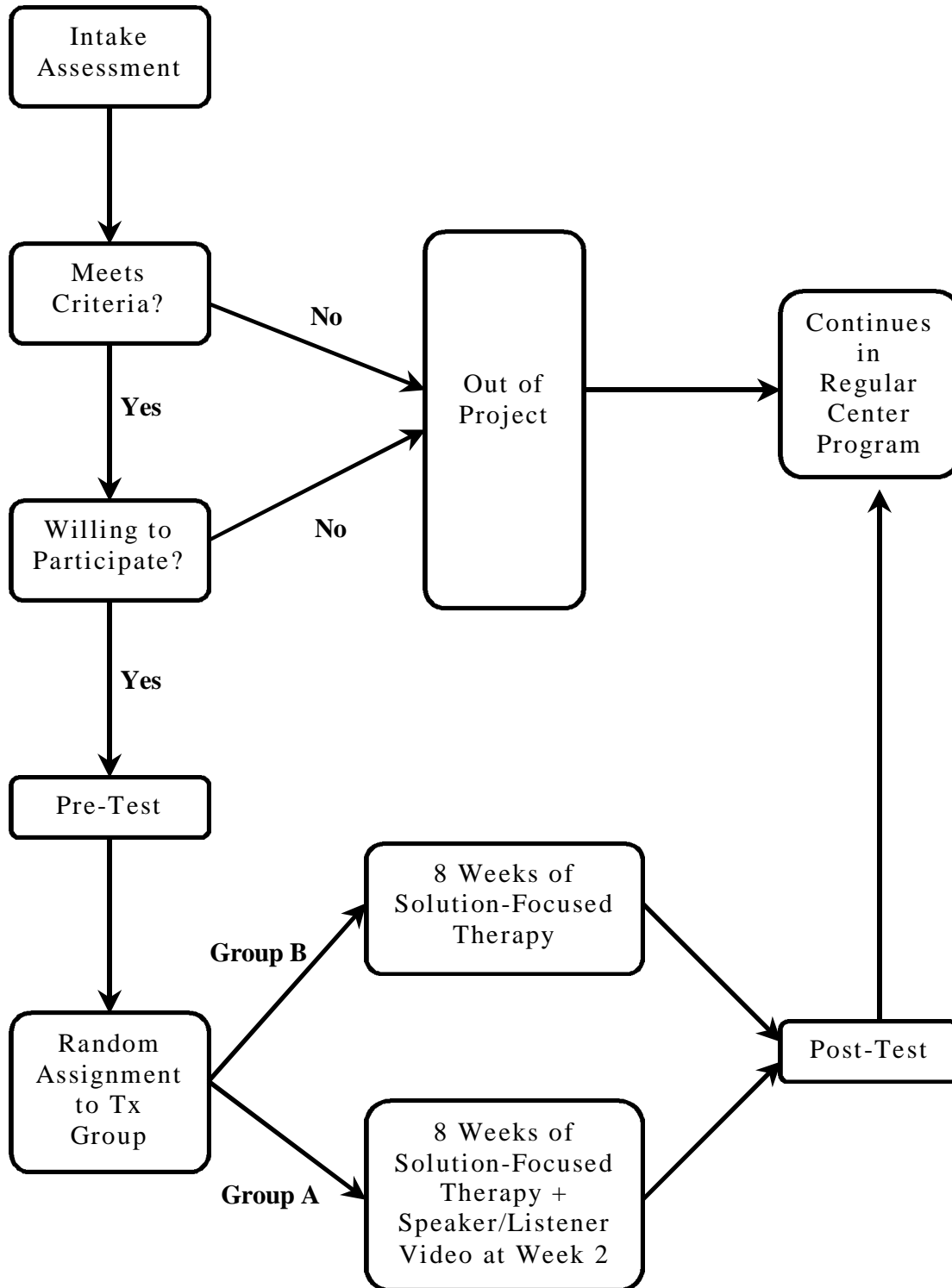


Figure 3.1

## **Instruments**

### The Dyadic Adjustment Scale

The Dyadic Adjustment Scale (DAS) was developed by Spanier (1976) and is designed to measure the quality of adjustment between marital couples or partners in a dyadic relationship. The DAS is a 32-item instrument that yields a total adjustment score based upon the scores of four subscales (Dyadic Consensus, Dyadic Satisfaction, Dyadic Cohesion, and Affectional Expression). Dyadic Consensus addresses a couple's level of agreement regarding issues such as money, religion, recreation, friends, household tasks, and time spent together. Dyadic Satisfaction measures the degree of tension within the relationship and to what extent each partner considers leaving the relationship. Dyadic Cohesion assesses the extent to which the couple shares common interests and activities. Affectional Expression measures each partner's satisfaction with the expression of affection and sex within the relationship. Reliability on the entire measure is high at .96. Additionally, reliability in the individual sub-scale is also very high: Dyadic Consensus (.90), Dyadic Satisfaction (.94), and Dyadic Cohesion (.86).

Because the DAS provides a total dyadic adjustment score for the individual as well as scores for each of the four subscales, an individual's scores can be analyzed and grouped in a number of different ways. By evaluating each of the individual subscales of the DAS as well as the total dyadic adjustment, it is possible to more readily identify the specific areas impacted by an experimental variable.

The DAS was administered to all participants before and after the eight weeks of treatment as a means of measuring the degree of change within the relationship. The DAS also allows the researcher the unique ability to gain some understanding of what aspects of the relationship are more or less impacted by the treatment. The DAS measures an individual's

adjustment to the relationship, not the overall adjustment of the relationship itself. For this reason client's individual scores to the DAS were not combined with those of their partner.

### The Kansas Marital Satisfaction Scale

The Kansas Marital Satisfaction (KMS) Scale (Schumm, Paff-Bergen, Hatch, Obiorah, Copeland, Meens, & Bugaighis, 1986) was developed to assess an individual's satisfaction with their spouse, with their marriage, and with their relationship as a whole.

The instrument consists of just 3 questions, each beginning with "how satisfied are you with..." your husband/wife as a spouse, with your marriage, and with your relationship with your husband/wife. The instrument uses a seven-point scale with response categories ranging from extremely dissatisfied to extremely satisfied (on a numeric scale of 1 to 7 points). The score is obtained by summing scores for the three individual items. Scores may range between 3 and 21, with a lower score indicating more dissatisfaction and a higher score greater satisfaction.

Mitchell et al. (1983) reported test-retest reliability for the KMS over a 10-week period of .71. Internal consistency analyses found alpha scores ranging from .89 to .98, with inter-correlations among items ranged from .93 to .95 (Schumm et al., 1983). Schumm et al. (1986) identified a significant correlation with the DAS and reported alpha coefficients on the individual sub-scales and the total score ranging from .75 to .94.

The data gathered from the KMS was used as a measure of change and relationship satisfaction. The scaling nature of the KMS was compatible with other types of scaling questions traditionally used with solution-focused therapy. The SFT model encourages therapists to ask their clients to evaluate a given situation by placing it on a scale of one to ten. A high number usually means a more favorable response. Questions such as, "How successful



do you think you were in reaching your goal” or “How would you rate your present situation” are commonly used to evaluate a client’s present state or perception.

### Additional Scaling Questions

Two additional scaling questions were asked each week in addition to the KMS. Clients were asked to evaluate the helpfulness of the session on a scale from 1-10 (1 being not at all helpful and 10 being very helpful). The client’s perception of their own progress was also assessed by asking the client to scale his/her present level of progress, as related to their goals, on a scale of 1-10 (1 being where they were when they first came to therapy and 10 being where they hope to be once therapy is over). These questions along with the three questions that make up the KMS were combined on one sheet to be completed by the client at the end of each session.

### ENRICH Communication Scale

The ENRICH Communication Scale (ECS) is a subscale within the ENRICH marital inventory (Olson, Fournier, & Druckman, 1983). The tool consists of ten questions addressing an “individual’s feelings and attitudes toward communication in his or her relationship. Items focus on the level of comfort felt by the partner in sharing and receiving emotional and cognitive information (Fowers & Olson, 1989).” Individuals respond to the questions such as “It is very easy for me to express all my true feelings to my partner” and “I often do not tell my partner what I am feeling because he/she should already know.” Response choices range from strongly agree to strongly disagree and are recorded on a scale of 1-5. Scores are determined by summing the total score for all questions. The higher the total score, the greater the level of satisfaction.

The communications portion of the ENRICH marital inventory has an alpha and test-retest reliability of .82 and .90 respectively (Olson, Fournier & Druckman, 1983).

#### Client Satisfaction Questionnaire - 8

The Client Satisfaction Questionnaire - 8 (CSQ-8) consists of eight questions intended to measure a client's over-all satisfaction with the therapeutic experience. Clients respond to questions such as, "How would you rate the quality of the service you received?" and "To what extent has our program met your needs?" Responses are recorded on a 4-point Likert scale, with higher scores indicating greater satisfaction. Psychometric properties of this measure are sound and well established (Attkisson, Larson, Hargreaves, LeVois, Nguyen, Roberts, & Stegner, 1989). Scores are achieved by summing the answers to all of the questions with higher scores indicating the greatest degree of satisfaction and lower scores indicating the least degree of satisfaction.

### **Data Analysis**

Data were analyzed based upon the research question being asked.

#### Question 1:

*Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in marital satisfaction than individuals who receive solution-focus therapy only?*

Pre to post-test difference scores were computed for each individual by subtracting their pre-test score on the KMS, and DAS, and the DAS subscales from the post-test score on each

measure. The mean difference scores were compared between groups with an Independent-Samples *t*-test.

Question 2:

*Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in satisfaction with their couple communication than those who receive solution-focused therapy only?*

Pre-test scores on the ECS were compared between groups A and B to assure that there was no significant differences between groups prior to treatment. Then, mean change scores were again determined by subtracting pre-test scores from post-test. An Independent-Samples *t*-tests was used to assess for any significant difference between the two study groups.

Question 3:

*Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting more satisfaction with the therapy process than those who receive solution-focused therapy only?*

Post-test scores on the CSQ-8 were compared between groups using an Independent-Samples *t*-test.

## CHAPTER FOUR: RESULTS

The purpose of this study was to investigate the effectiveness of a treatment plan, which integrated a highly directive communication technique with the solution-focused therapy model. Heterosexual men and women seeking couples counseling were provided eight weeks of therapy at a military counseling center. All data collected from participants in the study were analyzed on an individual basis. Three research questions were addressed by this study:

1) Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in marital satisfaction than individuals who receive solution-focused therapy only? 2) Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting more effective communication than those who receive solution-focused therapy only? 3) Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting more satisfaction with the therapy process than those who receive solution-focused therapy only?

### Reliability of Variables

Reliability was tested on the Dyadic Adjustment Scale (DAS), the Kansas Marital Satisfaction (KMS) Scale, the ENRICH Communication Scale (ECS), and the Client Satisfaction Questionnaire (CSQ-8). (See table 4.1)

The reliability for the Dyadic Adjustment Scale was determined for each of the four sub-scales as well as for the total DAS score. The DAS as a whole was found to have an Alpha = .85 (n = 18). This value is lower than that reported by Spanier (1976) of .92 for the entire 32-item scale, but still acceptable. Alpha scores for the individual sub-scales are as follows and are also

consistent with other studies: Consensus = .85; Satisfaction = .88; Affectional Expression = .72; and Cohesion = .80.

Table 4.1

### Summary of Reliabilities and Correlations

	Mean	Standard Deviation	Alpha	DAS Consensus	DAS Satisfaction	DAS Affectional Expression	DAS Cohesion	DAS Total Measure Score	KIMS	ECS	CSQ-8	AGE	Gender	# Years Married
DAS Consensus	38.9	9.5	0.85		0.53	0.37	0.60	0.85	0.48	-0.33	0.10	-0.20	-0.02	-0.22
DAS Satisfaction	25.7	9.4	0.88			0.43	0.59	0.86	0.77	-0.11	0.06	-0.03	0.04	-0.01
DAS Affectional Expression	6.5	2.8	0.72				0.35	0.56	0.53	-0.06	-0.37	-0.40	0.14	0.10
DAS Cohesion	11.1	4.7	0.8					0.79	0.61	0.01	0.15	-0.32	0.02	-0.18
DAS Total Measure Score	82.2	21.4	0.85						0.75	-0.20	0.04	-0.22	0.03	-0.13
KIMS	9.9	4.8	0.98							-0.22	0.03	-0.20	-0.20	-0.19
ECS	29.3	4.5	0.26								-0.18	-0.01	0.17	0.40
CSQ-8	28.1	6.1	0.97									-0.24	0.15	-0.74
AGE	32	7.4											-0.13	0.58
Gender	50% Male 50% Female													
# Years Married	6.3	6.6												

Correlation is significant at 0.05 or less (2-tailed).  
N ranges from 17 to 40N ranges from 17 to 40

The Kansas Marital Satisfaction scale was found to have a reliability of Alpha = .98 (n = 18). This is consistent with other studies that show high internal consistency, with alphas ranging from .89 to .98.

The ENRICH Communication Scale had a low level of reliability with Alpha = .26 (n = 39). This result is not consistent with findings of  $\alpha = .82$ ,  $n = 15,522$  reported by the developers of the scale (Fowers & Olson, 1989). Within group reliability was tested to determine if one group may have contributed to the lack of reliability of this instrument. Results indicated that group A (those who watched the video) produced an Alpha = .25 ( $n = 22$ ) while Group B (the no video group) produced an Alpha = .29 ( $n = 17$ ). Therefore, it was determined that neither group contributed to the lack of reliability more than the other.

The Client Satisfaction Questionnaire had a high degree of reliability with Alpha = .97 ( $n = 18$ ). This finding is consistent with other studies (Locke & McCollum, In press).

#### Testing Group Differences at Pre-Test

Independent-Samples *t*-test indicated no significant differences between groups on any of the instruments used by this study. Only on the Cohesion sub-scale of the DAS was significance approached at .077 (significance on other sub-scales and measures ranged from .350 to .943).

#### Testing Question One

*Question One: Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in marital satisfaction than individuals who receive solution-focused therapy only?*

The Dyadic Adjustment Scale and the Kansas Marital Satisfaction Scale were used to gather data relevant to this question. Because of the high degree of correlation between the two measures, it was decided that only data from the DAS would be analyzed.

The degree of change in marital satisfaction was determined by subtracting the values at pre-test from those at post. This produced a variable where positive values indicated an increase in satisfaction from pre-test to post-test, while negative values indicate a decrease in satisfaction. Individuals in group A, those who viewed the speaker/listener video were found to have an over-all mean change of 13.90 points on the DAS. Change for each of the sub-scales ranged from a total of 1.90 to 4.70. Individuals in group B, those who received solution-focused therapy but did not view the speaker/listener video, had an over-all mean change of 15.88 points. Change for each of the sub-scales for individuals in group B ranged from 1.63 to 5.75 (See table 4.2). Although individuals in group B did have slightly higher degree of mean change than did individuals in group A, the difference between the two groups was not statistically significant.

Table 4.2

**Degree of Change pre-test/post-test on DAS**

	Group	Mean	<i>t</i> -test for Equality of Means		
			<i>t</i>	df	Sig, (2-tailed)
Consensus	Video	4.7	-0.461	16	0.651
	No Video	5.75			
Satisfaction	Video	2.7	-1.057	16	0.306
	No Video	5.75			
Affectional Expression	Video	1.6	-0.035	16	0.973
	No Video	1.63			
Cohesion	Video	1.9	-0.623	16	0.542
	No Video	2.75			
Total Measure Score	Video	13.9	-0.289	16	0.777
	No Video	15.88			

## Testing Question Two

*Question Two: Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in satisfaction with their couple communication than those who receive solution-focused therapy only?*

The ENRICH Communications Scale was used to gather data. As with question one, degree of mean change was determined and analyzed (post-test – pre-test scores = degree of change).

At closure, group A (those who watched the speaker/listener video) had dropped in over-all satisfaction with their communication (mean change = -1.8), while at the same time group B increased by almost an equal amount (mean change = 1.5). There was a significant difference ( $t = -2.545$ ,  $n = 18$ ,  $p = .022$ ) between the groups, however the difference was in favor of those who did not watch the video (See table 4.3).

To further understand this finding, male and female scores were tested independently. There was no significant degree of difference between women who watched the video and those who did not. However, women in the video group reported a decrease (mean -2.0) in communication satisfaction, while those in the non-video group had no mean change. More interesting were the results of the men. Men who viewed the video also reported a decreased satisfaction with communication (mean change of -1.6). On the other hand, men who did not view the video reported an increase in satisfaction and had an over-all increase change in mean to be scores of 3.0. An Independent-Samples  $t$ -test found this difference in the male's results statistically significant ( $t = -2.699$ ,  $n = 9$ ,  $p = .031$ ).



Table 4.3

**Communication satisfaction change pre-test/post-test**

	Group	Mean	t-test for Equality of Means		
			t	df	Sig, (2-tailed)
ENRICH Communication Scale	Video	-1.8	-2.545	16	0.022
	No Video	1.5			

Because it was determined that two questions (8. “I am very satisfied with how my partner and I talk with each other” and 10. “My partner is always a good listener”) on the ENRICH Communication Satisfaction Survey seemed to best assess the intent of the speaker/listener technique, Independent-Samples *t*-tests were run on data collected by just those two questions. Again, mean change was first determined by subtracting pre-treatment scores from post-treatment. Means values increased (video = .90, no video = .63) on the question assessing satisfaction with how the couple talks to one another, and decreased (video = -.50, no video = -.25) on the question regarding the partner as a good listener. However, neither of these differences was significant.

Testing Question Three

*Question Three: Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting more satisfaction with the therapy process than those who receive solution-focused therapy only?*

For this question the Client Satisfaction Questionnaire was used to gather data. An Independent-Samples *t*-test identified difference between the two groups significant to .007.

Group A's mean was found to be 4.02 points higher than that of group B. Therefore, it can be safely assumed that couples who watched the video report more satisfaction with treatment.

## CHAPTER FIVE: DISCUSSION

### Purpose of the study

The intent of this study was to determine if the addition of a non-solution-focused intervention to the solution-focused model can enhance the over all effectiveness of the model. The specific intervention implemented in this study was a communications training video tape produced by PREP Inc. created to teach couples how to communicate in such a way as to increase understanding and decrease invalidation. Nine couples participated in a study designed to include eight weeks of solution-focused therapy with one half of the couples viewing the video during the second session, and the other half not viewing it at all.

The next three sections of this chapter will discuss the results by question.

### Discussion of Results for Question One

*Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in marital satisfaction than individuals who receive solution-focus therapy only?*

Although the findings indicate that there was no statistical difference between the two research groups in this study, it is noteworthy that the individuals in the group who did not view the videotape were found to have a higher degree of change. Couples who did not view the speaker/listener tape increased their total DAS score by 15.88 points while those who did increased by only 13.9 points. More intriguing are the results on the marital satisfaction sub-scale of the DAS. Couples not viewing the video had an increase of 5.75 while those who did increased by only 2.7 points. In reality, couples who did not view the video had a greater

increase in all areas of the DAS than couples who did, although those differences did not reach statistical significance. It is difficult to tell with such a small sample if these results have significant meaning, but it is possible to speculate about the findings. With differences in group means ranging from .03 to 3.05, there is a suggestion that the introduction of the speaker/listener video to the treatment plan may have decreased the over-all effectiveness of the therapeutic experience. Those who are advocates of solution-focused therapy may find this as evidence to support the notion that tampering with the model only serves to diminish its effectiveness. This kind of evidence does not bode well with those who seek to develop more integrated or eclectic treatment models.

However, these differences may be due to the fact that couples who were in the no video group had, in theory, one more session in which to address their issues. By including the video intervention as part of the treatment plan, couples who viewed the tape essentially lost a week of therapy. The video itself consumed nearly half of the session and a discussion regarding the technique taking up remainder. Couples who viewed the tape during session two seldom had time to address issues that may have come up during the week or were not discussed during the initial session. Nor, were they directly able to address issues other than communication which they may have been conflicted over.

Additionally, because marital satisfaction is impacted by a number of different factors, there is the potential that such a small dose of communication skills training as was implemented in this study did not establish a strong enough foundation upon which to base the remainder of treatment. Asking couples to view the tape early in treatment may have served to reinforce their own sense of dysfunctionality. By observing other couples using the speaker/listener technique in an effective manner, the couples viewing the tape may have become more aware of their own

inability to communicate effectively. This new awareness may have been further reinforced by the difficulty most couples had in implementing the technique in the discussion which ensued after viewing the tape. This may account for couples viewing the video reporting less of an increase in marital satisfaction than those who did not.

### Discussion of Results for Question Two

*Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting a greater increase in satisfaction with their couple communication than those who receive solution-focused therapy only?*

It is important to begin this discussion with a reminder that the tool used to measure satisfaction with communication had a very low level of reliability ( $\alpha = .26$ ), therefore, it is difficult to make any accurate conclusions based upon the findings of this study.

The failure of the communications training intervention to enhance the effectiveness of SFT may be due to both a lack of treatment potency and to insufficient statistical power. The communication component failed to add significantly to the treatment outcome possibly due to its insufficient duration and/or implementation. The speaker/listener technique is of a highly structured design and requires practice. Couples who participate in the PREP Inc. seminars are encouraged to practice the technique on a regular basis both in and out of a therapeutic setting. It is understood that couples will feel awkward using the technique at first, but become more comfortable with it in time. Couples in this project did not practice the technique in session on a regular basis and were left primarily on their own to practice it out side treatment.

The video is also designed as one of a four part series of videos to be viewed by couples who are experiencing conflict. By only viewing one video, it is possible that some critical aspects of the program were left out and therefore the technique may be less effective.

A study similar to this one (James, 1991) sought to integrate communications training with Emotionally Focused Therapy, and reported similar results. The author cited potency and duration as potential pitfalls of the study. However, that study placed communications training at the end of the treatment plan and implemented it for a total of four weeks. Each week of the communications training addressed a different skill related to good communication. Their findings indicated that upon follow-up, couples abandoned their new communication skills soon after treatment and indicated that longer exposure to the tools and/or increased practice would have been more helpful.

One of the potential problems in the design of this study may have been in its placement of the intervention. Greenberg and Johnson (1988) suggest that couples are best suited to acquire communication skills after their relationship bond has been strengthened. It has also been suggested that communication skills are best acquired after the appropriate emotions are attended too and the associated motivation toward change has been established (Greenberg & Johnson, 1988; Greenberg & Safran, 1987). By placing the intervention directly after the initial session it is possible that the clients may not have been ready to hear and implement the skills. James (1991) suggested that communication skills training be implemented earlier in treatment in order to allow for practice and familiarity with the tools. However, findings in this study lead to the conclusion that placing communication training too early in treatment may be unproductive.

There may also be an issue regarding fit between the solution-focus model's focus on the positive aspects of couple interaction and what seemed to be a more negative focus of the

ENRICH Communication Scale. While questions such as “I am sometimes afraid to ask my partner for what I want” and “Sometimes I have trouble believing everything my partner tells me” may be excellent starting points for looking for exceptions, they are not as positively focused as they should be in order to be compatible with the SFT model. Asking a more positive form of the same questions could collect the same data. (i.e. “I am seldom afraid to ask my partner for what I want” or “I can usually believe everything my partner tells me.”)

A couple (or individual) that does not see the relevance of an intervention is unlikely to adopt it as a part of their own solution. The questions and design of this study did not regulate and/or measure the application of the intervention. There was no clear directive to the therapists involved as to the manner in which they were to follow up on the communications training. Nor was there any measure used to evaluate to what degree the couples had heard, understood, and assimilated the communication techniques presented in the video. While the intent of introducing the speaker/listener technique to system was to add to the overall “solution”, if the couple (or individual) did not first identify those aspects of communication addressed by the technique as problematic then the question of fit must again be addressed. The solution-focused umbrella under which the study was conducted did not allow for the structure necessary for the application of this technique. Nor did it assume the deficiency in communication skills as did the video.

The conflict between the video intervention and the underlying treatment model (SFT) is evidenced by the unexpected suggestion of decreased communication satisfaction reported by the individuals who viewed the video. One can only speculate what could cause such a result, but with virtually all other areas (for both groups) indicating improvement, there is potentially a conflict between the intervention and the model.

### Discussion of Results for Question Three

*Do individuals who receive both solution-focused therapy and the speaker/listener tape end therapy reporting more satisfaction with the therapy process than those who receive solution-focused therapy only?*

While the difference in treatment was only minor from group to group, it is important to notice the statistical difference between groups.

In their book, *Escape from Babel*, Miller, Duncan & Hubble (1997) reported that it is the experience of the therapeutic process and the work of the client that result in therapeutic satisfaction, not the specific therapeutic model employed. The findings of this study serve, in part, to strengthen their claim. All of the couples involved in the study, regardless of their relationship satisfaction or progress toward desired goals, indicated a high degree of satisfaction with therapy (mean score = 28.1 out of a possible 32).

The findings from this study add to the growing pool of data which supports the over-all effectiveness of Solution-Focused Brief Therapy. Nearly all of the individuals involved in the study not only indicated improvement in those areas measured, they also reported being happy with the manner in which their needs were addressed. However, given the statistical difference between the two study groups, SFT can be improved upon in such a way as to increase client satisfaction with the therapeutic process.

It is difficult to identify what it was about the video that seemed to make a difference for couples in this study. Most of the couples who viewed the video tape reported having difficulty communicating and noticed the couples portrayed in the video had behaviors similar to their own. Therefore, there is the possibility that by viewing the video during the second session some clients may have felt validated that the therapist had heard and understood the concerns they



expressed in session one. This perceived understanding may therefore have allowed for greater joining between the clients and the therapist and in turn increased the client's ongoing level of satisfaction with the therapeutic process.

### Limitations

The fact that so few couples participated in this study clearly leaves some degree of uncertainty regarding the validity of the findings. The statistical power of such a small sample is low and may not have detected actual differences between groups. In addition, a one-time intervention, which fails to be followed up in subsequent sessions, may not constitute a significant difference in how the two groups were treated. The similarities in treatment of the study groups combined with the small sample size relates to the effect power has on the findings. In order to increase the probability of correctly rejecting a false null hypothesis, either the sample size would have to be increased or the treatment of the A and B groups would have to be made more different.

With regard to the communication skills training, a bigger "dose" of the treatment (i.e. repeated exposure or ongoing practice of the skills) may have altered the findings. If couples had been asked to practice the speaker/listener technique on a more regular basis, such as at the end of each session, or twice a week at home, the desired behaviors may have been more readily available in times of distress. Anecdotal evidence indicated that some couples found the structure of the technique mechanical and confining. These couples reported abandoning the tool for other forms of communication, which might not have had the same positive outcome.

After watching the video, one couple joked with their therapist about how funny the couples in the video had appeared. They discussed with each other how this form of

communication would never work for them. However, upon returning the next week, they reported to their therapist that they had had an opportunity to try out the technique and had been amazed at the result. Other couples, however, were unable to see the tool as potentially helpful and either abandoned the technique with only a few tries or never attempted to apply it at all.

Statistically, the reliability of the ENRICH Communications Scale was unacceptably low. Given the high degree of reliability reported by its authors, it is not clear why this came about. This may account for the results with regard to the impact on communication of the video intervention. If the measurement tool is not reliable, the findings are not trustworthy.

#### Post-Hoc Data Analysis

While the introduction of the speaker/listener tape to the treatment plan was not as helpful as intended, it was evident that therapy itself did make a difference.

Post-hoc analysis of data focused on determining if SFT alone is helpful. To do so, data collected from the two groups were combined, and analyzed as a whole. A Paired-Samples *t*-test on the pre-test and post-test DAS scores for all four sub-scales as well as the total DAS indicated that individuals involved in the study had improved. (See table 5.1)

Table 5.1

**Paired Samples *t* -Test on DAS Scores Pre-Test/Post-Test**

	Pre-treatment Mean	Post-treatment Mean	<i>t</i> -test for Equality of Means		
			<i>t</i>	df	Sig, (2-tailed)
Consensus	38.44	43.61	-4.670	17	0.000
Satisfaction	28.56	32.61	-2.820	17	0.012
Affectional Expression	6.56	8.17	-4.679	17	0.000
Cohesion	11.50	13.78	-3.422	17	0.003
Total Measure Score	85.06	99.83	-4.468	17	0.000

However, when the same data was analyzed, taking into account the client's gender, the results were different. Males showed a significant degree of change in all areas except dyadic cohesion, while females had no significant change in dyadic satisfaction. (See table 5.2) These findings support a common belief that gender is a factor when developing and implementing a treatment plan. There is a suggestion that cohesion, or feelings of being connected, to their partners is not a determining factor in their over all relationship satisfaction for males. However, females who are satisfied with the fundamental building blocks of their relationships may not be satisfied with the relationship as a whole. Therefore, the path taken toward creating an increased sense of marital satisfaction may be different depending upon the gender of the client.

Table 5.2

**Paired Samples *t*-Test on DAS by Gender**

		Pre-treatment Mean	Post-treatment Mean	<i>t</i> -test for Equality of Means		
				<i>t</i>	df	Sig, (2-tailed)
Consensus	Males	37.22	42.44	-3.344	8	0.01
	Females	39.67	44.78	-3.075	8	0.015
Satisfaction	Males	27.44	32.78	-2.399	8	0.043
	Females	29.67	32.44	-1.498	8	0.172
Affectional Expression	Males	5.89	7.78	-5.376	8	0.001
	Females	7.22	8.56	-2.219	8	0.057
Cohesion	Males	11	13	-2	8	0.081
	Females	12	14.56	-2.749	8	0.025
Total Measure	Males	81.56	96	-3.333	8	0.01
	Females	88.56	103.67	-2.872	8	0.021

Neither males nor females seemed to have made significant change on the ENRICH Communication Scale based on a Paired-Samples *t*-test. Again, the reliability of the scale was an issue and as a consequence any analysis of data is questionable.

Suggestions for Future Research

Most obviously, future studies would have to include a larger sample in order to assure more reliable results. It is also recommended that more appropriate measurement tools be selected in order to assess communication satisfaction in a more reliable manner. Additionally, placement and design of the communication training may also need to be altered. It is recommended that the communication training be placed somewhere toward the middle of treatment where couples may be more ready for the acquisition of skills. By addressing the immediate needs of the client and potentially providing them with some evidence of change, they may be more ready to take on and/or implement new skills. With regard to the solution-focused

model, by allowing more time to identify exceptions to poor communication within the dyad, the couple may be better suited to see the over-all helpfulness of structured techniques.

Future research may also seek to identify the effectiveness of video interventions. Some individuals indicated that they were a bit put off by the idea of coming to therapy to “watch TV” and were therefore less inclined to be open to what the program conveyed.

There is also an issue of fit between gender and the SFT model. Anecdotal evidence indicated that females seem to be more comfortable with this model. They were often more readily able to identify exceptions and envision how it would look when things were different. They also appeared to be more inclined to repeat a behavior (if not increase it) when complimented or validated on the effectiveness of that behavior. Males, however, seemed to respond to such compliments and/or validation with a more knowing attitude, as if they were already aware of the effect of their behavior, and were only bolstered in their confidence by the acknowledgement. While males in this study did appear to make behavioral changes, they seemed less inclined to associate changes in their spouses with changes in their own behavior. Therefore, males seemed less likely to repeat or increase some helpful behaviors. Research on integration may need to focus more on these differences in gender. Designing treatment plans which tap into interventions and modalities that address gender specific issues needs may be the new direction in research.

### Clinical Importance

The findings from this study serve to add to the increasing pool of knowledge in a number of different areas about what is and is not helpful to clients.

Findings from this study suggest that the integration of models and interventions is a delicate matter requiring technique and art. Selection of interventions to integrate with a given treatment model must take into account both the nature of the model and the intervention as well as the needs of the client. Some interventions work better than do others with some clients and, likewise, so do some models. Clearly most therapists pull from many different models when treating their clients. It is difficult not to tap into anything that works when the goal is to be helpful, but the mechanics of this form of integration are difficult to define. In most cases, integration of this sort takes place out of necessity rather than by design.

While there is research to indicate that no one therapeutic model is any better than another, it is clear from the results of this study that SFT is generally an effective form of treatment. If one considers the ever-increasing popularity of this model, it appears the therapeutic community agrees. Clients participating in this study reported at termination that they like how things “did not seem so negative all the time” and how “it was nice to start noticing that the glass was half full.” While it may be difficult for some clients to notice change at first, many in this study reported that it was the therapist’s repeated questioning of what had improved that got them to recognize that things were getting better.

### Summary

This study attempted to integrate a one-time communication skills training video with the Solution-Focused Therapy model. Nine male-female couples participated in the project. Analysis of data address marital satisfaction, satisfaction with communication, and over-all satisfaction with therapy.

No significant evidence was identified which indicated that the integration of the SFT treatment model and the video intervention was more effective in increasing satisfaction with communication than was SFT alone. However, individuals who viewed the speaker/listener communication video reported being significantly more satisfied with their therapy experience. There was also significant evidence to suggest that SFT promotes change. Evidence also suggests that males and females respond to SFT in significantly different ways.

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# VITA FOR JAMES MUDD

## ACADEMIC PREPARATION

**Master of Science, Marriage and Family Therapy, Virginia Tech.** Completed requirements for degree during November 2000. Acquired 53 graduate hours with a 3.76 G.P.A; and 600 direct client clinical hours serving families, couples and individuals. Completed clinical internship at the two following locations:

- Three year clinical internship at the Center for Family Services, Virginia Tech, in Falls Church, Virginia.
- Two year internship with the Chaplain Family Life Ministry and Training Center, Fort Belvoir, Virginia

**B.S. Biology, 1986.** Radford University, Radford, Virginia.

## RELATED VOLUNTEER ACTIVITIES

Student and Faculty mentor, Parkside Middle School, 1991-2000

Young Life Leader and Counselor, Fairfax, VA, 1986-1991

## RELATED EDUCATION

Certified with Life Innovations, Inc. as a PREPARE/ENRICH approved counselor, 2000

Six hours of training with Cloe Madanes related to conducting therapy with abused children and their families, 2000

Thirty-nine hours of post-graduate credits in Biology, Education and Psychology, 1986-1995

## RELATED WORK EXPERIENCE

7<sup>th</sup> Grade Life Science Teacher, Parkside Middle School, Manassas, VA, 1991-2000

Biology and Applied Biology Teacher, Osboun Park High School, Manassas, VA, 1989-1991

Biology and Plant Science Teacher, Lake Braddock Secondary School, Burke, VA, 1988-1989

Biology Teacher, West Springfield High School, Springfield, VA, 1987-1988

## **APPENDICES**

## **Appendix A**

# INFORMED CONSENT

## For Research at the Chaplain's Family Life Center

What is being studied?

This study is designed to add to existing research regarding the solution-focused therapy model, relationship satisfaction, and the over-all effectiveness of specific therapeutic interventions. All findings will be used to strengthen the understanding therapists and counselors have in how to be most helpful to their clients.

What will I have to do?

Fill out questionnaires before your first session, and after the eight weeks of treatment or when you decide to end treatment (whichever comes first). Filling out questionnaires should take no more than twenty minutes.

Complete a five question questionnaire at the end of each session. Answering these questions should take no more than five minutes.

What are the benefits and risk?

You will help better the understanding of treatment models and interventions which work best with couples like yourselves.

There is little risk in participating in this study. You will receive counseling services that are based on models of treatment which have been researched and found to be helpful in many other situations.

Like in any therapy setting, you may be asked to talk about upsetting or difficult issues.

Is it private?

All the information you provide related to your treatment or this research study is confidential.

The researcher will not share your answers to any questionnaire items with your therapist or anyone else, although, you are free to discuss the questions and your answers in therapy if you wish.

In the unlikely event that your answers to any questionnaire item should lead the researcher to believe that you are a danger to yourself or others, or that a child or dependent adult has been abused, the researcher will have to report this information to the appropriate authorities.

Your name will not be associated with any of the measurement tools you are asked to complete. Your research materials will be identified by case number only. Neither your name nor potentially identifying information will be used in any publications or professional presentations that might come from this project. All completed research materials will be stored in locked files and will be available only to the researcher.

Can I quit if I want to?

Participation in this study is voluntary. You may withdraw from the study at any time.

If you wish, you may withdraw from the study at any time and continue to receive services from the Family Life Center. You may even choose to withdraw and continue to work with your present therapist.

Approval of research

This research project has been approved, as required, by the Institutional Review Board for projects involving human subjects at Virginia Polytechnic Institute and State University, and the Chaplain's Family Life, Ministry and Training Center.

Participants' agreement and responsibilities

I have read and understand what my participation in this project entails and I know of no reason that I cannot participate in this project. I have had all my questions answered and hereby give my voluntary consent for participation in this project.

Should I have any questions about this project or its conduct, I can contact any of the following: Jim Mudd, Principal Investigator (703-805-2742); Chaplain Jim Jones, Center Supervisor (703-805-2742); Dr. Eric McCollum, Department of Human Development, VA Tech (703-538-8463); Dr. H. T. Hurd, Chair of the Virginia Tech IRB (540-231-5281).

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Signature

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Date

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Printed Name

## **Appendix B**

### **Solution-Focused Worksheet – First Session**

Client Name: \_\_\_\_\_ Case # \_\_\_\_\_ Date: \_\_\_\_\_

#### **History & Complaints:**

**Who is the customer? For What?**

**Goals: (How will you know when you can stop coming here? Miracle question for self & others.)**

**Exceptions: (Times when small pieces of miracle are already happening?)**

#### **Scaling Questions:**

**Pre-session improvement:**

**Motivation to behavioral change:**

**Confidence: (hopefulness of changes, commitment to take steps, maintaining changes, etc.)**

**Other scales:**

**Message: (Compliment and Suggestions/Task)**

## Solution-Focused Worksheet – Later Session

Client Name: \_\_\_\_\_ Case # \_\_\_\_\_ Date: \_\_\_\_\_

**What is better?**

**No change?** Review goals, review customership, proper problem? Ask coping questions. New Goals?

**What does the client need to do more?**

**Scaling Questions:**

**Current Level:**

**What would it take to move up on the scale?**

**Confidence: (Maintain current level for how long?)**

**Other scales:**

**How close to termination?**

**Message: (Compliment and Suggestions/Task)**