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A STUDY OF INTAKE AND ASSESSMENT IN
SOLUTION-FOCUSED BRIEF THERAPY

by

Christopher J. Richmond

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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Department of Counselor Education and Counseling Psychology
Dr. Alan Hovestadt, Advisor

Western Michigan University
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A STUDY OF INTAKE AND ASSESSMENT IN SOLUTION-FOCUSED BRIEF THERAPY

Christopher J. Richmond, Ph.D.

Western Michigan University, 2007

The purpose of this study was to compare clients' assessment of two different counseling intake procedures used by clinicians. This study compared a Solution-Focused Brief Therapy (SFBT) intake intervention with an intake intervention constructed from the Structured Clinical Interview for the *DSM-IV* Axis I Disorders (SCID-I). The SCID-I is one of the most widely used diagnostic interviews and reflects a "gold standard" in formulating accurate diagnoses. The SFBT intake intervention developed for this study stands in stark contrast to the SCID-I and its primary objective, evaluation of the problem. SFBT is a strength-based model that maintains a positive and future-oriented focus. This model is deliberate in its focus on initiating and maintaining discussions of strengths, resources, and solutions as opposed to problems.

Many mental health agencies believe that a comprehensive psychological intake interview or assessment, in which information is gleaned from a broad array of areas, is essential in determining the client's appropriateness for counseling and planning a successful course for treatment. However, little attention has been given to the intake interview or assessment, as well as different intake procedures and their impact as experienced by the client.

Client assessments of the SFBT and the SCID-I intake intervention were examined with regard to counselor attractiveness, expertness, trustworthiness, and total effectiveness; session depth, smoothness, positivity, and arousal; outcome optimism and goal clarity; and client's current level of distress.

The sample consisted of 30 clients, which included 16 female and 14 male participants. An equal number of participants received the SFBT and SCID-I intake intervention. This study employed a mean comparison design in which participants' outcome scores on the two intakes were assessed. Participants were randomly assigned to either treatment A (SFBT intake) or treatment B (SCID-I intake). A series of *t* tests was conducted on each of the dependent variables based upon the mean scores from the participants within the SFBT and SCID intake groups. Results revealed no statistically significant differences between the two intake assessments, thus suggesting that the SFBT intake intervention was comparable to the SCID-I intake intervention in regard to the selected outcome variables.

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During this journey of my dissertation I have experienced several significant accomplishments and frustrations. At those times I turned to my relationship with God to offer thanksgiving for the accomplishments and ask for wisdom and understanding during the frustrations.

Interestingly, my clinical and research involvement with Solution-Focused Brief Therapy has helped me more clearly define my own strengths and resources. In examining myself through this journey, I found that I often turn to faith and prayer as a strength and resource. Following accomplishments and frustrations I have reflected upon the following passage from Psalm, "O Lord, you have searched me and you know me. You know when I sit and when I rise, you perceive my thoughts from afar. You discern my going out and my lying down; you are familiar with all my ways. Before a word is on my tongue you know it completely, O Lord. You hem me in behind and before; you have laid your hand upon me" (Ps. 139: 1-5 New International Version).

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CHAPTER I

INTRODUCTION

Statement of the Problem

Many mental health professionals believe that a comprehensive psychological intake interview or assessment, in which information is gleaned from a broad array of areas, is essential in determining the client's appropriateness for counseling and planning a successful course for treatment (Cavanagh, 1982; Eckstein, Baruth, & Mahrer, 1992; Fine & Glasser, 1996; Hood & Johnson, 1991; Lazarus, 1997; Mosak, 1995).

Furthermore, mental health agencies, regardless of their intake procedures or setting, are charged with the task of adequately interviewing and assessing clients during the intake (Fine & Glasser, 1996; Shertzer & Linden, 1979). Psychotherapy research has indicated that clients do experience therapeutic benefits as a result of the intake assessment (Hood & Johnson, 1991; Talmon, 1990). However, little attention has been given to the intake interview or assessment, and in particular its impact as understood by the client. For the purpose of this study the author will use the terms intake interview and intake assessment interchangeably.

This study will attempt to identify whether or not there are differences between a Solution-Focused Brief Therapy (SFBT) intake assessment intervention and an intake intervention constructed from the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I; First, Gibbon, Spitzer, & Williams, 2002) on measures of counselor

credibility, which encompasses counselor attractiveness, expertness, and trustworthiness; session depth, smoothness, positivity, and arousal; outcome optimism and goal clarity; and client's current level of distress. This research will seek to examine the effectiveness of SFBT, as well as contribute to the literature pertaining to the early stages of therapy, namely the intake assessment.

Background of the Problem

Several research studies have indicated that between 40.8% and 49.0% of all clients fail to return to counseling following the intake interview (Betz & Shullman, 1979; Garfield, 1994; Sue, McKinney, & Allen, 1976). There has been much debate over the reasons for which clients fail to return to counseling following the intake interview. Age, gender, race, and socioeconomic status are some of the variables that have been implicated in failure to continue counseling post-intake interview. Although some relationship has been found between these demographic variables and discontinuation of therapy, there is still no adequate explanation for this phenomenon (Garfield, 1994; Noonan, 1973; Weisz, Weiss, & Langmeyer, 1987).

Historically, this phenomenon has largely been considered a negative event and labeled "client dropout" or "premature termination." However, research within the area of single session therapy has indicated that some clients experience significant symptom relief following the intake interview (Hood & Johnson, 1991; Talmon, 1990). Therefore, one hypothesis for "premature termination" might be that a client comes to the conclusion that the intake assessment was all that was needed to produce adequate symptom relief and thus he or she chooses to discontinue therapy.

As researchers have broadened their focus from traditional process and outcome studies, there has developed a trend towards assessing the outcome of therapy at periods other than at the point of termination (Garfield, 1994). For example, immediate outcomes or micro-outcomes can be meaningfully assessed after any session, or intermittently over the course of treatment (DeRubeis & Feeley, 1990; Gale & Newfield, 1992; Greenberg & Pinsof, 1986; Rice & Greenberg, 1984). Greenberg and Pinsof refer to this as the small chunk model of psychotherapy research. According to this model of research, the intake assessment could be assessed to determine its impact. Presently, only a modest amount of literature exists in regard to the client's evaluation and perceived impact of the intake interview (Rudolph et al., 1993).

The small chunk methodology of assessment will provide the framework to evaluate the impact of SFBT at the level of the intake assessment. Greenberg and Pinsof (1986) have indicated that researchers should employ clinical theory in selecting specific therapeutic events to be examined. The theoretical understanding that change can occur as a result of the intake interview provides the evidence and the basis for examining this particular therapeutic event (Hood & Johnson, 1991; Talmon, 1990). Thus, an intake interview could be assessed at the micro-outcome level after a brief time following the conclusion of the intake assessment.

The research and practice literature germane to the intake interview suggests a strong connection between this component of psychotherapy and the medical model. Proponents of SFBT, De Jong and Berg (2002) have stated that the medical model still holds a strong influence in the helping professions. The influence of the medical model is apparent in the intake interview as evidenced by the diagnostic nature of the session,

which usually incorporates some form of assessment, mental status examination, and psychological or psychiatric testing (Talmon, 1990).

It is important to consider that if the purpose of the intake interview is to gather data, assess, and make a diagnosis, it is unlikely that the counselor will have an opportunity to explore the client's strengths and resources. Within the "medical model-version" of the intake interview there exists an emphasis on exploring the past and problems rather than the future and solutions. The crux of the matter is that when the content of the intake interview is focused almost exclusively on exploring and assessing the problem, it is likely that some clients will at least initially feel demoralized and without a sense of relief from the problems that they had presented with (Talmon, 1990).

Within the current SFBT research literature, relatively little is known about the effectiveness of SFBT germane to the intake interview. Although there is no SFBT intake assessment per se, SFBT does offer a framework in which an intake assessment can be constructed. An intake assessment developed within this framework would assess client strengths and resources, as well as help clients to more clearly envision their future devoid of the problem that has brought them to counseling (De Jong & Berg, 2002; Lipchick & de Shazer, 1986).

In the last two decades, published solution-focused brief therapy (SFBT) literature has grown considerably. Furthermore, SFBT has become a more widely accepted therapeutic approach in the United States, as well as in other countries (Gingerich & Eisengart, 2000). SFBT has been successfully employed in university clinics, mental health settings, residential treatment centers, prisons, schools, and private practice (De Jong & Hopwood, 1996; Eakes, Walsh, Markowski, Cain, & Swanson, 1997;

LaFountain & Garner, 1996; Lambert, Okiishi, Finch, & Johnson, 1998; Lindforss & Magnusson, 1997; Triantafillou, 1997; Zimmerman, Jacobsen, MacIntyre, & Watson, 1996). Although SFBT has grown in popularity and acceptance, it has not yet built robust empirical evidence indicating clinical efficacy (De Jong & Hopwood, 1996; Gingerich & Eisengart, 2000).

In a review of the SFBT outcome research, Gingerich and Eisengart (2000) examined 15 studies. Of these 15, only 5 were considered to be well-controlled studies. Studies were considered to be well-controlled if they met 5 of the 6 following criteria: (1) use of a randomized group design or single-case design; (2) focus on a specific disorder; (3) comparison of an experimental treatment with a standard, placebo, or no treatment; (4) use of treatment manuals and procedures for monitoring treatment adherence; (5) use of outcome measures with documented reliability and validity; and (6) use of a sample large enough to detect group differences (Gingerich & Eisengart, 2000). The above criteria were adapted from the American Psychological Association's (APA) standards for assessing empirical support for psychological treatments (Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

In order to advance the clinical efficacy of SFBT, further research will need to be conducted with the methodological rigor set forth in the above stated criteria for assessing empirical studies. Gingerich and Eisengart (2000) identified common limitations of the current SFBT outcome literature. In regard to these limitations they highlighted recommendations for remediation that include the following: the need for proceduralization of SFBT, consistent use of detailed treatment manuals and treatment

adherence measures, as well as controlling for the effects of counselor expectancies and allegiances (Gingerich & Eisengart, 2000).

Purpose of the Study

Although SFBT has grown in popularity and acceptance, it has not yet built robust empirical evidence indicating its clinical efficacy (De Jong & Hopwood, 1996; Gingerich & Eisengart, 2000). The present research will seek to examine the effectiveness of SFBT, as well as contribute to the literature pertaining to the early stages of therapy, namely the intake interview.

Solution-Focused Brief Therapy (SFBT) Intake Assessment

The SFBT intake assessment (Appendix B) was constructed from the stages of solution building described in the work of De Jong and Berg (2002), de Shazer (1988), de Shazer et al. (1986), and Lipchick and de Shazer (1986). Additionally, the European Brief Therapy Association (EBTA) has developed the EBTA outcome study research definition, which includes the minimal requirements for the first session of SFBT. The EBTA minimal requirements for the first SFBT session include the utilization of the following techniques: (a) Miracle Question and follow-up questions as needed, (b) Scaling Question and follow-up questions as needed, and (c) Compliments offered to the client at the end of the session (Beyebach-Salamanca, 2000).

The SFBT intake assessment for the present study will follow de Shazer's (1988) flowchart for the first counseling session. Moreover, the SFBT intake assessment will utilize the following: Pre-Treatment Change Question, Complimenting, Miracle

Question, Exception Question or Coping Question, Scaling Question, and Identification of Client Strengths and Resources. The Coping Question will be employed if the client is unable to respond to the Exception Question.

Definition of SFBT Terms

This study will utilize terminology intended to convey specific meanings that may require explicit description. These terms and definitions are provided below.

Compliments: Compliments are primarily employed in SFBT with the purpose of drawing the client's attention to their positive changes, strengths, and resources. This can be done via direct compliments, indirect compliments, or calling attention to compliments that a client may pay to himself or herself. A direct compliment is a positive evaluation or reaction by the counselor in response to the client. For example, a counselor might compliment a client for being on time and participating in their first session by saying, "You seem to be motivated and invested in making your current situation better." An indirect compliment is a question that implies something positive about the client. For example, an indirect compliment could imply that the client knows what is best for them. More specifically, the client could be asked: "How did you know that it was important for you to make this appointment and follow through by attending and participating?" Finally, any client mention of a self-compliment should be highlighted in an effort to reinforce possible signs of progress (De Jong & Berg, 2002).

Coping Question: The SFBT coping questions are helpful when attempts to elicit exceptions and future hopes are met with negativity and a denial that anything positive is happening or could ever happen. These questions help to join with the client's despair,

while gently directing him or her toward acknowledgement of resources and the possibility of change. Coping questions awaken the client's awareness to the amount of effort that it has taken just to remain stable (i.e., not get better, but not get any worse). Once this awareness is realized, the client develops an appreciation for what has occurred, and is then in a better position to make some changes in an effort to capitalize on the energy he or she has already used. For example, following a problem-saturated discussion about a client's work environment, a counselor could ask what in particular the client has been doing to prevent the job situation from getting worse (De Jong & Berg, 2002).

Exception Question: These SFBT questions attempt to elicit from the client information about behavior that occurs at times when the problem is not a problem or when it is less of a problem (de Shazer, 1988). Clients often come with a problem-saturated view of themselves or of others. News that there are times that the problem does not exist is frequently a "difference that makes a difference" (Bateson, 1972, p. 453). For example, clients might explain significant problems in their marital relationship. However, when asked an exception question that orients them to times in their relationship when they get along better, they might respond with an answer that indicates that the problem is greatly diminished when the two of them are doing something cooperatively, such as making dinner together.

Miracle Question: The miracle question is an SFBT technique that can help facilitate the process of setting goals for therapy. Responses to this question should be concrete, behavioral descriptions about what the client and others will be doing differently after the miracle has happened (De Jong & Berg, 2002).

Now I want to ask you a strange question. Suppose that tonight, while you are asleep, a miracle happens. The miracle is that the problem that brought you here is solved. However, because you are sleeping, you don't know the miracle has happened. So, when you wake up tomorrow morning, what will be different that will indicate to you that this miracle has in fact happened and the problem that brought you here is now solved? What else? (de Shazer, 1988, p. 5)

In responding to this question, the client should provide small yet reasonable expectations that he or she can meet. Furthermore, responses to this question should include specifics about whom, where, and when, but not why. Finally, responses should also state what the client would be doing rather than what he or she would not be doing (De Jong & Berg, 2002).

Pre-session Change: The therapeutic task of assessing for pre-session change involves an inquiry about change within the time between when the client scheduled the appointment, and the beginning of the intake interview. For example, a counselor could ask, "About a week ago you called us to schedule this appointment. What changes have you noticed between then and now?" This question conveys the message that change is inevitable, and it often occurs even prior to the intake assessment (Lawson, 1994; Ness & Murphy, 2001; Talmon, 1990; Weiner-Davis, de Shazer, & Gingerich, 1987).

Scaling Questions: Scaling questions provide clients with an opportunity to put their observations, impressions, and predictions on a scale from 0 to 10. Additionally, these questions can provide clients with an accurate self-assessment of their problems, and their level of confidence in treatment (Berg & Reuss, 1998). For example, a client might be asked, "On a scale from 0 to 10, where 0 indicates no chance and 10 indicates every chance, what do you think are the chances that Tim will do the laundry today?"

When asking scaling questions, the counselor should cite a specific time in the client's

life, such as today, to have an explicit frame of reference in responding. Responses to scaling questions also prove to be useful for the counselor to assess the client's progress (De Jong & Berg, 2002).

Identification of Client Strengths and Resources: SFBT places a general emphasis on exploring and identifying client strengths and resources. This process, although not associated with a particular question in this model, is often accomplished via exploring the client's exceptions to the problem situation. For example, at the end of the SFBT interview the counselor asks, "Are there any other strengths or resources you have that we have not talked about?" Furthermore, clients can be complimented for their strengths and their ability to employ them effectively in problem situations (De Jong & Berg, 2002).

Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)

The Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I: First, Gibbon, Spitzer, & Williams, 2002) is a broad, semi-structured instrument that adheres closely to the *DSM-IV* decision trees for psychiatric diagnosis. The SCID-I has modules that enable clinicians to administer only the most relevant sections pertaining to their clinical work or research. In this particular study, the Overview and SCID Screening modules will be employed (Appendix C).

CCPS Standard Intake Interview

The major components of the CCPS intake interview (Appendix A) include the following: (a) Presenting Problem or Concern; (b) Expectations for Counseling; (c) Current Situation; d) Family Background and Family History of Mental Illness;

(e) Relevant Medical and Psychological History; (f) Prior Counseling Experiences; and (g) Recommendations in regard to their future counselor's gender, and available days and times for counseling.

Research Questions

Counselor Rating Form–Short Version (CRF-S)

Research Question: Are there any differences between participants' views of counselor (a) expertness, (b) trustworthiness, (c) attractiveness, and (d) total effectiveness, as measured by the CRF-S, in an SFBT intake assessment in comparison to the SCID-I intake assessment?

Session Evaluation Questionnaire (SEQ)

Research Question: Are there any differences in session depth, smoothness, positivity, and arousal as measured by the SEQ, in an SFBT intake assessment in comparison to the SCID-I intake assessment?

The Immediate Outcome Rating Scales (IORS)

Research Question: Are there any differences in outcome optimism and goal clarity as measured by the IORS, in an SFBT intake assessment in comparison to the SCID-I intake assessment?

Outcome Questionnaire (OQ-45.2)

Research Question: Are there any differences between participants' change in global distress scores from a pre-intake administration and second administration prior to the subsequent counseling session, as measured by the OQ-45.2, in an SFBT intake assessment in comparison to the SCID-I intake interview?

Organization of the Remainder of the Study

A review of the related literature is provided in Chapter II, followed by a description of the methods and procedures in Chapter III. Data are analyzed and reported in Chapter IV, and discussion and recommendations are summarized in Chapter V.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

The purpose of this chapter is to provide a review of the literature on Solution-Focused Brief Therapy (SFBT). This chapter will begin with a review of SFBT that will include the history and philosophical assumptions of this therapeutic approach. Next, it will describe the history of the Structured Clinical Interview for *DSM-IV* (SCID-I) and the components of this interview that will be employed in the present study. The final section of this chapter will review and critique the related SFBT outcome research literature.

Evolution of SFBT From Brief Psychotherapy

Historically, brief psychotherapy or time-limited therapy has been viewed as a superficial and expedient treatment to be employed only in crisis situations until long-term therapy could be accessed (Garfield, 1994). However, brief psychotherapy has been considered a treatment of choice for many patients (Wells & Phelps, 1990). As mental health professionals have experienced a dramatic rise in the demand for their services, there has been a strong need to provide care within a time-limited framework. Brief therapy is considered a legitimate form of psychotherapy and is no longer viewed as an inadequate or shallow mode of treatment (Garfield, 1994; Koss & Shiang, 1994; Talmon, 1990).

Of the factors that have contributed to the contemporary emphasis on brief therapy, health care availability and cost might arguably be the most influential (Garfield,

1994). Health care availability and cost became a major social debate in the mid 1980s (Cummings, 1986). Subsequently, mental health care has been charged with a mandate to provide high quality treatment in a cost-efficient manner to a broad range of clients (Bloom, 1992; Talmon, 1990). The 1990s advent of managed care has also increased the focus on treatment outcome and efficiency.

The current models of brief psychotherapy have evolved from two major traditions, the first being conventional long-term psychodynamic models, and the second being interactional family systems models. Early brief models were based on the conventional psychodynamic treatments, often maintaining the same theoretical views as the longer-term treatments. Furthermore, these models employ extensive exclusionary criteria, such as not treating personality disorders, and narrow therapeutic goals in lieu of using brief therapy techniques (Sifenos, 1987).

Distinct from the psychodynamic-based brief therapy models, interactional family systems-based brief therapy models were developed to be limited in length and suitable for a broad array of client concerns (Fisch, Weakland, & Segal, 1982). One of the most innovative models of interactional brief therapy was developed at the Mental Research Institute (MRI). The aim of the MRI was to develop the briefest possible treatment for psychiatric disorders. The MRI model evolved into an active approach that focused on the presenting symptom and was limited to 10 sessions. This model theorizes that problems originate and are maintained through ongoing problematic interactions. These problematic interactions represent a family's failed or inadequate attempts at solving a particular problem. The MRI model seeks to change the rules that support the problems embedded in these interactional patterns. Furthermore, this model prescribes and

facilitates alterations in current solution attempts, thus resulting in more effective solution attempts (Nichols & Schwartz, 2001; Weakland, Fisch, Watzlawick, & Bodin, 1974).

The Solution-Focused Brief Therapy (SFBT) model developed at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin, by Steve de Shazer, Insoo Berg, and colleagues was an outgrowth of the MRI model. The SFBT model differs from the MRI approach in that it explores examples of solution behaviors and exceptions to problems. The models are similar in their stance on utilizing the client's behaviors to assist him or her in formulating solutions, as well as a focus on establishing a cooperative therapeutic relationship (Miller, Hubble, & Duncan, 1996).

Main Theoretical Principles of SFBT

Solution-Focused Brief Therapy (SFBT) is based upon a social constructivist view of reality. The constructivist view implies that an individual's reality is developed through interactions and conversations with others. Furthermore, language labels and provides meaning to our thoughts, feelings, and actions. Constructivism suggests that meaning evolves and changes through the dialogue between people as they share their experiences. From this framework, counseling becomes an interactional or joint experience with the aim of mutually negotiating and understanding reality, problems, and goals. In essence, the function of therapy is the co-construction, by counselor and client, of a solution as well as the process of attaining that solution (Walter & Peller, 1992). Additionally, SFBT emphasizes that clients are the experts regarding their mental health and they ultimately determine the therapeutic goals. This principle highlights the importance of client autonomy (de Shazer & Berg, 1992).

Furthermore, SFBT is a strength-oriented model that maintains a positive and future-oriented focus. This model employs language and conversation that assumes the possibility of change. SFBT is deliberate in its focus on initiating and maintaining discussions of strengths, resources, and solutions as opposed to problems. The implication is that it is therapeutically more productive to discuss the futuristic path to the clients' desired outcome, rather than exploring the development and etiology of the problem. When clients are engaged in conversations about solutions or exceptions to the problems, they form mental representations of themselves solving the problem. Following this conversational focus on solutions, clients often begin to talk as if they can play an active role in the process of achieving their goals. Furthermore, they begin to more actively envision themselves within their world of solution possibilities (Walter & Peller, 1992).

de Shazer and his colleagues at the Brief Family Therapy Center (BFTC) believe that most complaints that clients present with in counseling develop and are maintained in the context of daily interactions. It is assumed that clients have the skills to solve their problems but have only lost sight of how to use their skill set to solve the current dilemma. Moreover, clients are adaptive, creative, and resilient, and they enter counseling with unique abilities, resources, values, and challenges. Solutions are available within the changing interactions, which occur within the context of the unique circumstances of daily events (de Shazer et al., 1986).

An additional belief of the BFTC is that a new and positive meaning can be constructed from at least some aspect of the client's complaint. de Shazer et al. (1986) suggest that any action can be seen from a variety of points of view, and the meaning that

action has been given depends on the observer's construction or interpretation. Thus, developing an alternative view of the problem situation can provide an understanding of the context in which certain aspects of this situation may be beneficial.

In regard to change, the BFTC believes that no matter how complex or bleak the client's current situation, a small change in one person's behavior can lead to profound and far-reaching differences in the behavior of all persons involved. Therefore, the number of people who are successfully constructing the problem and the solution does not necessarily matter. It is suggested that change is constantly occurring, whether it be positive, neutral, or negative. Clinical experience and research has confirmed the notion that small change is generative and leads to further and more substantial improvements. In other words, momentum in the positive or desired direction can occur from small and seemingly inconsequential changes (Walter & Peller, 1992).

As related to client cooperation, SFBT maintains that clients are cooperative and do want to change for the better. Some theoretical orientations have labeled particular client behaviors, such as not participating in a therapeutic task, as resistance or noncompliance. However, SFBT proposes a different understanding of this behavior, which suggests that it is a client's way of implying that a particular task is not helpful. The SFBT approach to building cooperation in the therapeutic relationship suggests connecting the present to the future by highlighting what clients are already doing that is good for them. Moreover, cooperation can be built through exploring the past for client successes as opposed to client failures (de Shazer et al., 1986).

Another central SFBT principle suggests that effective therapy can be conducted without the counselor having fully understood the client's presenting problem. Moreover,

it is not necessary for the counselor to seek detailed descriptions of the problem or to construct a rigorous explanation of how the problem is maintained. Instead of exploration of the problem, the BFTC states that the most important thing for the counselor to understand is the client's goals for therapy. de Shazer et al. (1986) suggest that any different behavior in a problematic situation can be enough to prompt solution and give the client the satisfaction they seek from therapy.

SCID-I History, Overview, and Screening Modules

The Structured Clinical Interview for *DSM-IV-TR* Axis I Disorders (SCID-I) is a semistructured interview used to determine the presence of axis I diagnostic criteria. It is one of the most widely used diagnostic interviews by both research investigators and clinicians. In regard to administration, a trained clinician or an individual familiar with the *DSM-IV* diagnostic criteria can administer the SCID-I. This interview includes an introductory overview and screening module (Appendix C) followed by subsequent modules that assess major axis I diagnostic classes. The subjects may include either psychiatric or general psychotherapy patients. The language and diagnostic coverage of the SCID make it most appropriate for adults 18 or older. The modular construction of the SCID-I allows it to be easily adapted (through eliminating modules that are not of interest) for use in studies in which a particular diagnosis might be of interest. The SCID-I employs a decision tree approach that directs the clinician in testing diagnostic hypotheses during the interview. The data from the SCID-I provide a record of the presence or absence of symptoms related to particular axis I disorders (Spitzer, Williams, Gibbon, & First, 1992).

The SCID-I has well-established psychometric properties. This instrument demonstrates a fair level of interrater agreement, with a *K* coefficient of above .60 for patient samples being assessed for major depression and lifetime diagnoses (Reich & Noyes, 1987).

In regard to the history of the SCID, it was the publication of the *DSM-III* in 1980 that revolutionized the diagnostic conceptualization of mental disorders. The *DSM-III* was the first comprehensive publication to specify diagnostic criteria for almost all of the mental disorders. Prior to 1980 there existed several sets of diagnostic criteria, such as the Feighner Criteria and the Research Diagnostic Criteria. Both of these diagnostic measures were accompanied by structured interviews designed to establish diagnoses consistent with their respective criteria. Aimed with the knowledge that the *DSM-III* would become widely adopted as the norm for classification of mental disorders, work progressed in an effort to establish a comprehensive instrument for making *DSM-III* diagnoses. That comprehensive instrument was the SCID. The SCID integrated several unique features that would facilitate its use in research, such as the inclusion of an Overview section that allows the patient to describe the development or exacerbation of the current episode of illness (Spitzer et al., 1992).

In 1983 Spitzer and his colleagues, Williams, Gibbon, and First, were awarded a National Institute of Mental Health grant to further research and develop a standard clinical diagnostic assessment procedure for making *DSM-III* diagnoses. Prior to being awarded the grant, Spitzer and his colleagues had amassed preliminary data from a small pilot study using the beginnings of what would be the SCID. Continuing in this research, Spitzer was awarded a two-year grant to field test the SCID in order to establish its

reliability in clinical as well as nonclinical subject groups. During this period the American Psychiatric Association published and released revisions of the *DSM-III*. The publication of the *DSM-III-R* (*R* indicating Revised edition) provided a unique opportunity for Spitzer and his colleagues to further develop and revise the SCID along with the *DSM-III*. Following the end of the SCID field trial in 1987, the SCID has undergone numerous revisions that have mirrored the revisions in the *DSM* (Spitzer et al., 1992).

The present study will utilize the Overview and Screening modules of the SCID-I. The Overview section employs open-ended questions that assess the present illness or exacerbation and history of past episodes of psychopathology. This section does not assume a principal complaint, but provides an opportunity for the client to explain the presenting problem in his or her own words. More specifically, the Overview section includes an opportunity to collect valuable information pertaining to prior psychotherapy treatment (including psychotropic medications), social and occupational functioning, and the development of the psychopathology. Included in the Overview is a Life Chart form. This form can be used when a client has a complex or lengthy history of previous psychotherapy treatment. The Life Chart form provides space to record the date, description of symptoms, and treatment specific to a particular episode of mental illness. The Overview concludes with the Screening section that includes 12 “yes” or “no” response-style questions. These questions are extracted from the body of the SCID and represent the initial questions inquired by the SCID for specific disorders (First et al., 2002).

SFBT Efficacy Studies

The following section will review SFBT outcome studies. Many of the SFBT outcome studies evaluated below were located in Gingerich and Eisengart's (2000) review of the SFBT outcome research. The studies included in this review have been grouped into two sections one comparing SFBT to no treatment and the other comparing SFBT to problem-focused treatments. The following studies were selected because each included some degree of experimental control, included a control group, and assessed client outcomes in regard to client behavior or functioning. Additionally, this review included research that examined both end of treatment outcomes and intermediate therapy outcomes.

SFBT Compared to No Treatment

Seagram (1997) conducted a study examining the efficacy of SFBT as a treatment approach with 40 young offenders living in a correctional self-contained facility. The offenders ranged in age from 16 to 19 years old. The majority of these youth offenders committed multiple crimes or were single-time offenders of violent crimes. The author employed a pre-posttest group design, comparing a treatment group of participants who received SFBT to the control group that received no treatment. Participants in both groups continued to receive biweekly visits from their social worker; this was the only variation of counseling provided to the control group.

In regard to results, the author found that the members of the treatment group had made more progress in solving their problems than the control group using the Solution

Focused Questionnaire as a pre-post measure. Furthermore, the author found that the treatment group reported a greater level of optimism for the future than the control group members, as measured by the Carlson Psychological Survey (CPS). Seagram also found that the treatment group members reported lower scores on the Chemical Abuse Scale (CAS) as compared to the control group following treatment. However, there were no differences found between the treatment and control groups using the Jesness Behavior Checklist (JBC). The JBC assesses anger control, unobtrusiveness, and conformity. Furthermore, there were no changes between the treatment and control groups within the areas of family functioning, peer interactions, and externalized behavior problems. Additionally, the author reports that the observer ratings conducted by teachers, who had regular contact with the participants, indicated very little change in behavior for either group (Seagram, 1997).

In regard to limitations of this study, Seagram served as the author and treatment provider for this study. Additionally, Seagram conducted the group assessment sessions during which the participants completed each of the instruments. As a result of the author performing multiple roles within this study, there existed the strong likelihood of therapist allegiance and expectancies. Furthermore, the assessment sessions were conducted in a group format exposing participants to the author and other participants, thus providing the potential for participants to experience some level of coercion. A final limitation was the absence of a manualized treatment approach. These limitations threaten the internal validity of the study and thus impact its validity as a whole.

Lindforss and Magnusson (1997) conducted a study that examined the efficacy of SFBT within a criminal population at Hageby Prison in Sweden. The researchers

employed an experimental two-group design with the measurement of outcome at two points in time, once at 12 months and again at 16 months following treatment. The selected outcome variables were recidivism and seriousness of repeated offenses. The 60 participants in this study were prisoners that had more than 2 months of sentence to serve at the time of their incarceration. Participants that consented to this study were randomly assigned to the experimental and control groups, with each group containing 30 participants.

The control group received no treatment, while the experimental group received an average of five SFBT counseling sessions. The participants in the experimental group received anywhere from 1 to 12 sessions of SFBT. The SFBT counseling sessions were administered by a treatment team which consisted of two private practice family therapists and a project leader. The results at the 12-month measurement of outcome indicated that of the 30 participants in the experimental group, 16 committed a new offense (53%), while of the 29 in the control group, 22 had committed a new offense (76%). The difference between the two groups was found to be statistically significant. The unequal sample sizes were due to the fact that one member in the control group died from a drug overdose. Furthermore, at the 16-month follow-up, similar results were found, which indicated that the experimental group's rate of recidivism increased to 60% and the control group's rate of recidivism increased to 86%. The authors indicated that the greatest difference in recidivism between the experimental and control group was the higher rate of drug offense arrests within the control group. This study reported that twice as many in the control group relapsed into drug offenses following treatment (Lindforss & Magnusson, 1997).

In regard to limitations of this study, there were no comparison treatment groups that utilized an alternative mode of therapy. Therefore, this study is limited in the conclusions that can be made regarding SFBT's efficacy as compared to other treatments designed to reduce recidivism. Another significant limitation is the lack of a treatment manual and procedures for monitoring adherence of SFBT in the experimental group sessions. The lack of a standardized SFBT treatment model was evident by the wide range in SFBT sessions delivered (1–12) to participants, and the length of these sessions (1–4 hours). This study did not review the experimental group sessions to verify adherence of SFBT. Therefore, there are no data to suggest that each SFBT session included an equal number of SFBT interventions.

SFBT Compared to Problem-Focused Treatments

Jordan and Quinn (1994) conducted a study that was designed to evaluate the treatment effects in a single counseling session between a solution-focused and problem-focused approach. The 40 subjects that participated in this study included families, couples, and individuals. The authors used an experimental two-group design in which they randomly assigned participants to either the solution- or problem-focused treatment group. There were a total of 25 subjects in the problem-focused therapy group and 15 in the solution-focused group.

The authors compared the two groups using the Working Alliance Inventory (WAI), Handy Outcome of Psychotherapy and Expectancy Scale (HOPES), and the Session Evaluation Questionnaire (SEQ). The results from the WAI indicated that there was no overall significant difference between groups on working alliance. Furthermore,

there were no differences between groups on results that indicated participant's level of personal attachment and goal identification. Analysis of the HOPES revealed statistically significant differences between the two groups, indicating higher levels of perceived problem improvement and outcome expectancy in the solution-focused treatment group. The participants in the solution-focused group reported higher levels of perceived problem improvement and outcome expectancy. The results from the SEQ indicated statistically significant differences between the groups, indicating higher levels of session depth, smoothness, and positivity among the participants in the solution-focused treatment group (Jordan & Quinn, 1994).

The authors of this study clearly detailed the interventions employed in both treatment approaches and established treatment assurance using two independent observers. In regard to limitations of this study, there were no outcome variables that specifically assessed actual problem resolution or reduction in presenting symptoms. Furthermore, the solution-focused approach included only three interventions. Those SFBT interventions were the miracle question, exception question, and formula first session task (FFST). The FFST asks the clients to pay attention to things that happen in their lives that they would like to see happen more frequently.

Adams, Piercy, and Jurich (1991) completed a study that investigated the immediate impact of an SFBT intervention on the family and therapist. More specifically, this study examined the differential effects (a) of the SFBT's formula first session task (FFST), (b) in addition to the FFST in combination with SFBT, and (c) as compared to a problem-focused strategic intervention followed by problem-focused therapy. A total of 45 couples and families from a university marriage and family therapy center, as well as

15 families from a social service agency, participated in this study. This study employed a three-treatment group, follow-up experimental design with random assignment of participants to each of the three treatment conditions. The three groups were assessed using the following four outcome measures: the Compliance Rating Scale (CRS), Termination Status Form (TSF), Pretreatment Status Form (PSF), and Immediate Outcome Rating Scale (IORS).

The first experimental group was asked the FFST at the end of the first session, and at following sessions therapy was conducted using SFBT. The SFBT interventions employed included the exception question, eliciting family strengths, and identification of family interactions at times when the problem is absent. The second experimental group utilized the FFST at the end of the first session, but then conducted following sessions from a problem-focused strategic orientation. The control group utilized a problem-focused task that asked families to closely observe their problems between sessions so that they could report these concerns at their next session. In addition, the control group conducted subsequent sessions from a problem-focused strategic orientation (Adams et al., 1991).

The results of this study suggested that both experimental groups demonstrated statistically significant improvements over the control group on measures of goal clarity and treatment compliance. There were no differences between the three groups for outcome optimism. Therapist ratings of problem improvement indicated a statistically significant difference between the experimental and control groups. More specifically, therapists reported a 60% improvement in the problem within the FFST group, as opposed to a meager 25% improvement within the control group (Adams et al., 1991).

Although the aim of this study was to specifically assess the FFST, it only utilized this technique in addition to two additional SFBT interventions in the experimental groups. Furthermore, the length of treatment was not equivalent across all three groups. More specifically, the range of sessions reported indicated that the lengthiest treatment average was for the control group (11.5), and the shortest treatment average was for the experimental group that combined the FFST with SFBT (8.85). The authors employed the TSF to assess progress in treatment; however, this instrument does not specifically assess reduction in the clients' presenting symptoms, thus making it difficult to accurately assess this construct. A further concern about the design of this study is that the therapists had significantly more training and exposure to the problem-focused than the solution-focused treatment approach. The majority of therapists that participated in this study indicated that their theoretical orientation was structural/strategic, and the primary model of treatment at the center where this study was conducted is structural/strategic and problem-focused. It is likely that the following data may have resulted in the therapists being biased and more effectively delivering the problem-focused than the solution-focused therapy.

Littrell, Malia, and Vanderwood's (1995) research examined a single-session of brief counseling in a high school setting. This naturalistic study investigated the differential effects of three brief counseling approaches: problem-focused counseling with a task, problem-focused counseling without task, and solution-focused counseling with a task. The problem-focused brief counseling without a task served as the control group. The 61 participants involved in this study were enrolled in a large Midwest high school. All participants were randomly assigned to one of the three treatment conditions

described above. Three therapists were trained in the problem-focused and solution-focused therapies, and then administered all sessions to the participants. The counseling sessions ranged in time from 20 to 50 minutes with an average of 40 minutes. Following this single session, the participants were asked to come back for two follow-up assessment meetings. These meetings were conducted at 2- and 6-week intervals post-treatment. The researchers assessed the extent to which students' concerns had been alleviated, percentage of goal achievement, and intensity of undesired feelings. These three areas were assessed quantitatively using a 7-point Likert-type scale.

Litterel et al. (1995) found that the three therapeutic approaches did not differentially alleviate the participants' concerns. At the first follow-up meeting, 54% of the participants from all three groups reported that their concern had improved, 38% indicated that it was the same, and only 5% indicated the concern had worsened. At the second follow-up, results indicated a 14% increase in the number of students that reported their concern had improved. Furthermore, across all three approaches at the first follow-up, 75% of the participants noted that they had reached 50% or more of their goal. Moreover, at the second-follow-up, 90% had reached 50% or more of their stated goal.

In regard to limitations, the authors described the advantages and disadvantages of their naturalistic research design. Litterel et al. (1995) explained that the assessment of participants' goal attainment was conducted collaboratively with the counselor. They reported that this arrangement provided the counselors with immediate feedback and was rather typical under nonexperimental conditions. However, this arrangement may have likely caused the participants to feel some level of coercion. Additionally, the counselors may have unduly influenced the ratings to reflect a greater level of goal attainment, and

thus efficacy on their behalf. As related to the dependent variables, there were no standardized outcome measures employed in this study. Thus, the absence of standardized measures compromises the study's internal validity.

Sundstrom (1993) investigated the differential outcome of a single session of interpersonal therapy and solution-focused therapy for depression. The author employed a randomized experimental study in which 40 female graduate students were randomly assigned to either the experimental or control group. The participants were considered appropriate for this study if they scored 10 or higher on the Beck Depression Inventory (BDI). The author's treatment condition included a variety of specific SFBT techniques, such as the exception question, miracle question, complimenting client strengths/resources, and the Formula First Session Task. The control condition involved specific problem-focused interventions as detailed by the manualized treatment of depression with interpersonal therapy. The length of treatment for both conditions was one 90-minute counseling session. The sessions were conducted by 21 female licensed social workers, licensed psychologists, psychology interns, and advanced psychology graduate students.

Following the one session of therapy, the participants were asked to return within 7–10 days for a follow-up interview. During this interview, the participants were asked to complete the following four assessments: BDI, Depression Adjective Checklists (DACL), Rosenberg Self-Esteem Scale (SES), and the Counselor Rating Form–Short Form (CRF-S). The analyses suggested overall client improvement for both treatments from pretreatment to follow-up as indicated by scores on the BDI and the DACL. Therefore, a single session of therapy was associated with an immediate improvement in mood that was sustained for at least a week. However, neither the experimental or control group

produced significantly greater outcomes than the other. The results from the SES indicated no change following treatment for either treatment condition. Furthermore, the CRF-S results suggested that counselor characteristics did not impact the treatment outcome (Sundstrom, 1993).

Sundstrom's work represents a well-controlled study that utilized a sound experimental design and robust standardized outcome measures. Additionally, she employed a treatment adherence check in which the counseling sessions were videotaped and reviewed by trained raters. However, it is important to note the limitations of this study. Most obvious is that all of the counselors and participants are female, thus limiting the ability to generalize the findings of this study to males. The design of this study crossed counselors with treatment conditions, thus allowing for counselors to deliver both treatment conditions. This was suggested so that counselor variables would not influence the overall impact of the treatments. However, Sundstrom reported that only 33% of the counselors conducted both treatment conditions because of scheduling difficulties and time constraints. Therefore, it is reasonable to conclude that therapists' factors could have influenced the results of this study.

Speicher-Bocija's (1999) research examined the relationship between solution-focused interview statements, problem-focused interview statements, and differential client responses. This research also assessed how differential client responses and clients' locus of control affected self-efficacy estimates. The author employed a comparison group pre-posttest, true experimental design. The participants were randomly assigned to one of six therapists, and then randomly assigned to either the solution-focused or problem-focused session following the intake assessment. A total of 20 outpatient clients

participated in this study. At the conclusion of the solution-focused and problem-focused sessions, participants completed the Post-Session Questionnaire (PSQ), the Counseling Goal Self-Efficacy Questionnaire (CGSEQ), and the Self-Efficacy Scale (SES). Additionally, internal locus of control was assessed between the assessment and treatment sessions using the Internal Control Index (ICI).

The results of this study indicated only limited support for the hypothesis that predicted significant differences in the expected and observed frequencies of relationships between therapist and client response modes on the variables of gathering problem, neutral, and positive information. The author explained that due to the skewed nature of the response modes, the results limited the ability to complete tests of significance. The remainder of the data indicated that neither the client nor therapist response modes were able to predict posttest general self-efficacy. Furthermore, there were no improvements in prediction of posttest self-efficacy over pretest self-efficacy by knowledge of interview type or internal locus of control. In regard to the qualitative data collected, the author found that participants that received the solution-focused session indicated the utility of focus and goal setting. However, those participants in the problem-focused sessions described the presence and value of insights into their behavior (Speicher-Bocija, 1999). In regard to limitations of this study, the small sample size of only 20 participants reduced the power of the analysis employed. The small sample size also limits the ability to generalize the findings of this study to other populations. Furthermore, many of the outcome measures lacked adequate reliability and validity.

Conclusion

SFBT is a novel therapeutic approach that has gained anecdotal evidence indicating success from both counselor and client. This review of the SFBT outcome research provides preliminary support for its efficacy beyond the anecdotal data. Gingerich and Eisengart (2000), in a recent review of the SFBT literature, indicated that SFBT is moving from an open trial phase of investigation toward an efficacy phase. This present study will utilize the strengths of previous SFBT outcome studies, and it will also take into account and make adjustments based upon the limitations of previous research. Moreover, the present study will provide a unique examination of SFBT at the intake interview.

To date, no SFBT outcome study has specifically assessed this therapeutic approach exclusively at the intake assessment. The intake assessment is particularly significant within the debate between problem-focused and solution-focused interventions due to the overwhelmingly diagnostic and problem focus of most intake interviews and assessment measures, such as the SCID-I (De Jong & Berg, 2002; Talmon, 1990).

In regard to the limitations of previous outcome studies, many of the previous studies reviewed in this chapter have lacked proceduralization of SFBT. Additionally, some of these studies employed only a small number of SFBT techniques. The present study has addressed this limitation by utilizing an SFBT intake assessment protocol, which includes several SFBT techniques. This protocol will help to ensure that the SFBT assessment will be consistently administered across the counselors and research sites. Furthermore, many of the previous studies have not employed treatment adherence

measures. This study includes a videotape and audiotape review of all intake assessments by independent raters as a means to verify adherence to both the SFBT and SCID-I protocol.

Furthermore, methodological flaws in some of the previous research have included lack of random assignment, inadequate outcome measures, and researcher allegiance. The present study will utilize random assignment within a mean comparison design. The outcome measures for the present study were selected based upon their reliability and validity, and ability to effectively measure symptomology and distress, counselor and session characteristics, outcome optimism, and goal clarity. Last, researcher allegiance was addressed by removing the principal student investigator from the training, treatment delivery, and assessment components of this study.

This study represents a rigorous design that has been developed to examine the effectiveness of the SFBT intake in comparison to the SCID intake. The design of this study was based in large part upon the recommendations for future outcome research detailed in the Gingerich and Eisengart (2000) review. This review suggested (a) implementation of treatment manuals to provide proceduralization of SFBT, (b) utilization of treatment adherence measures, (c) use of several SFBT techniques, and (d) controlling for the effects of therapist expectancies and allegiances. As noted above this study utilized SFBT and SCID-I intake interview scripts in order to provide proceduralization of both treatments. Furthermore, this study employed treatment adherence measures to ensure that the counselors followed the protocols for both intakes. The SFBT intake interview used in this study employed a total of six unique SFBT

interventions. Therapist expectancies and allegiances were controlled for as a result of the researchers removing themselves from the treatment implementation process.

CHAPTER III

METHODOLOGY AND DESIGN

The purpose of this study was to investigate the relative effects of the SFBT and SCID-I intake assessment intervention on client's evaluation of counselor credibility, which includes counselor attractiveness, expertness, trustworthiness, and total effectiveness; session depth, smoothness, positivity, and arousal; outcome optimism and goal clarity; and client's current level of distress.

Statistical Analysis

This study employed a mean comparison design in which participants' outcome scores on two types of intakes were assessed. Participants were randomly assigned to either treatment A (SFBT intake) or treatment B (SCID-I intake). The first set of *t* tests was conducted on the dependent variables: session depth, smoothness, positivity, and arousal as measured by the SEQ. The second set of *t* tests was conducted on counselor attractiveness, expertness, trustworthiness, and total effectiveness as measured by the CRF-S. And, the third set of *t* tests was conducted on outcome optimism and goal clarity as measured by the IORS. In regard to the OQ-45.2, the difference in the participants' overall distress score from the pre-intake and the subsequent counseling session administration was assessed between the two treatment groups. This difference in scores was also analyzed using an independent *t* test.

The counselors who conducted these assessments received both the SFBT and SCID intake trainings. They were instructed to deliver intakes following a random assignment list of administration. Each counselor had their own unique random assignment administration list that included an equal number of both intakes. Of the six counselors, three conducted an equal number of each intakes, whereas the other three conducted at least one of each but did not conduct an equal number of both.

Sample

Client Participants

Thirty-seven clients consented to participate in this study, of which 30 completed all of the required outcome measures. Each of the 7 that did not complete the entire survey packet failed to return to counseling following the intake assessment, and thus did not complete the OQ-45.2 for the second and final administration. Of the 30 clients who fully participated in this study, 16 were female and 14 were male. Ages ranged from 18 to 57, with a mean age of 26.27 and a mode age of 19. In regard to race, 22 participants reported their race as Caucasian/White (Non-Hispanic), 3 reported Hispanic-American, 2 indicated African-American, 2 reported Multi-Racial, and 1 indicated American Indian. With respect to relationship status, 25 were single, 2 were divorced, 1 was married, 1 was partnered (currently living with their partner), and 1 was separated. This sample included 10 participants who indicated that they were full-time students, 7 noted they were part-time employed in a permanent job, 6 indicated they were full-time employed in a permanent job, 2 reported they were full-time parent or homemaker, 2 noted they were

full-time employed in a temporary or summer job, 1 indicated unemployed and looking for temporary employment, 1 noted unemployed and not looking for employment, and 1 did not respond to this question. The final demographic item was highest level of education attained, and 17 participants reported that they had attained a high school diploma or its equivalent, 5 noted that they had earned an associate's degree, 5 reported that they had earned a bachelor's degree, 2 indicated that they had not completed high school, and 1 noted having earned a master's degree.

In regard to the 7 participants who did not return to counseling following the intake session and thus did not complete the entire survey packet, 3 were administered the SFBT intake assessment and 4 were administered the SCID-I intake assessment. Of these 7, 4 were female and 3 were male. Ages ranged from 21 to 30, with a mean age of 23.43 and a mode age of 22. In regard to race, 6 participants reported their race as Caucasian/White (Non-Hispanic) and 1 indicated African-American. With respect to relationship status, 5 were single, 1 was married, and 1 was partnered (currently living with their partner). This group included 3 participants who indicated that they were full-time students, 2 noted they were full-time employed in a permanent job, 1 noted full-time student and part-time employed in a permanent job, and 1 noted full-time student and full-time employed in a permanent job. The final demographic item was highest level of education attained, and 6 participants reported that they had attained a high school diploma or its equivalent and 1 reported an earned bachelor's degree.

Counselors

A total of four WMU counseling psychology doctoral students and two master's level limited licensed psychologists from Ferris State University (FSU) participated in the delivery of both the SFBT and SCID intake assessments for this study. In regard to gender, there were three male counselors and three female counselors. Ages ranged from 25 to 55, with a mean age of 39.17. Each of the six counselors reported their race as Caucasian/White (Non-Hispanic). Furthermore, all six of the counselors reported that their highest degree attained was a master's degree, and all but one noted that they are currently pursuing a doctoral degree in either clinical or counseling psychology. In regard to clinical experience, the responses ranged from 3 years to 31 years, with a mean of 10.83 years. Counselors' experience conducting intake assessments ranged from 2 years to 30 years, with a mean of 10.17 years. All of the counselors indicated that they had previously received training, supervision, and coursework specific to psychopathology and psychiatric assessment using *DSM-IV* diagnostic categories. In regard to primary theoretical orientation, three counselors reported their orientation as eclectic, two noted cognitive-behavioral, and one reported family systems.

Procedures

Data Collection Process

Locations of Data Collection

Three data collection sites were chosen for the present study. The first site chosen for data collection was the Western Michigan University (WMU) Center for Counseling and Psychological Services–Grand Rapids (CCPS-GR). The client base for CCPS-GR consists primarily of community referrals and court-mandated clients. The CCPS in Kalamazoo (CCPS-KZ) was the second site chosen for data collection, which consists of community referrals in addition to WMU students. The final site was the Ferris State University (FSU) Counseling Center in Big Rapids, Michigan. This Counseling Center provides individual counseling exclusively to currently enrolled university students.

Client Participation

Adult clients seeking individual counseling were recruited from CCPS-GR, CCPS-KZ, and the FSU Counseling Center. At each data collection site, clients were invited by their intake counselor to participate in this study following completion of the intake paperwork but prior to the intake assessment. This invitation and a short description of this study were included in the recruitment script (Appendix D), which was read verbatim by the counselors to the prospective client participants. The intake paperwork at CCPS-GR and KZ consists of the following documents: (a) Statement of Professional Intent; (b) Client Information Sheet, (c) Telephone Message Agreement,

(d) Informed Consent Document, and (e) Outcome Questionnaire (OQ 45.2). The intake paperwork at the FSU Counseling Center consists of the following documents:

- (a) Confidential Pre-Counseling Statement, (b) Informed Consent Document, and
- (c) Outcome Questionnaire (OQ 45.2).

Potential participants were screened using the data obtained via the CCPS and FSU intake paperwork that requests demographic data and information pertaining to the presenting problem. Participation was restricted to adults age 18-70. Additionally, any client who reported symptoms of a psychotic disorder, and/or reported being suicidal or homicidal was not asked to participate. Last, any client who was unable to consent to treatment due to a mental impairment was not asked to participate.

In regard to the informed consent process, those clients who indicated a willingness to participate in this study after being read the recruitment script were given the consent form (Appendix E). Following clients' review of the consent form, they were given the opportunity to ask their intake counselor any questions they might have about participation and/or the study. Clients who agreed to participate signed the consent form. This consent form outlined the intentions of the study, the voluntary nature of participation in the study, and the process by which client information would be kept confidential. Those clients who chose not to participate at CCPS-GR and KZ were administered the standard CCPS intake interview (Appendix A), as was also the case at the FSU Counseling Center.

After clients consented to participate, they were randomly assigned to either the SFBT or the SCID-I intake assessment intervention. Each participant was first administered the SFBT or SCID-I portion of the intake intervention in which the primary

focus was to explore the presenting problems or concerns. The SFBT and SCID-I portion of the assessment was videotaped at CCPS-GR and KZ and audiotaped at the FSU Counseling Center for research purposes, and the process of recording and storing these sessions was explained to the participants in the consent form.

After completion of this first portion of the intake assessment, the counselor stopped the video or audio recording, at which time the counselor then instructed the participant to open the study packet (Appendix F) and begin responding to the three outcome measures (SEQ, CRF-S, and IORS). The average length of the SFBT intake intervention was 20 minutes, and the average for the SCID was 18 minutes. Each participant completed the survey packet in private after the counselor had exited the therapy room. In regard to the fourth and final outcome measure, the OQ-45.2, the standard operating procedures at CCPS-GR, KZ, and the FSU Counseling Center request that clients complete this assessment preceding every session. Thus, the researchers asked for the participants' permission to access their OQ-45.2 scores from their clinical file for the intake and subsequent counseling session. The completion of the second OQ-45.2 concluded the participant's involvement in this study.

After participants had completed the three outcome measures, they were instructed via written directions to enclose the measures back in the envelope, and return it to the research drop-box located at the reception desk. At this point, the counselor and participant reconvened in the counseling room to complete the standard CCPS or FSU intake assessment excluding the questions pertaining to presenting problems or concerns. Therefore, the intake counselor assessed the following areas after the SFBT or SCID-I intervention portion of the interview: (a) Current Situation, (b) Family Background,

(c) Relevant Medical History, (d) Relevant Psychological History, and (e)

Recommendations. If for some reason the counselor explored any of the five areas listed above during the SFBT or SCID-I portion of the interview, he or she was instructed not to ask any redundant questions during the later portion of this interview.

Client Protection and Confidentiality

Clients were asked to refrain from putting any identifying information on the survey packet and the outcome measures. The survey packets and outcome measures were coded using a four-digit code number. Code numbers were used to identify participants and to link survey packets with demographic data and OQ-45.2 scores from the client files. Participants were asked to give permission to the researchers to access their OQ-45.2 scores for both the intake and subsequent session administrations. A master list of code numbers and names were stored in a locked file cabinet in the principal investigator's office. After data entry was complete, the master list was destroyed.

The videotapes and audiotapes were used to ensure that the clinicians adhered to the SFBT and SCID-I intake research protocols. At CCPS-GR and KZ, two WMU Counselor Education doctoral students in the Counselor Education and Counseling Psychology (CECP) department served as trained raters, along with and under the direction of Dr. Gary Bischof. Dr. Bischof is a professor, licensed marriage and family therapist, and accomplished researcher who has published several articles on the application of SFBT. He has also worked in several mental health treatment settings in which traditional diagnostic intakes similar to the SCID-I were used. The doctoral student raters were trained in evaluating the two intake protocols. Additionally, they and Dr.

Bischof viewed practice role-play intakes by the intake workers prior to rating research intakes on their own. This served to enhance interrater reliability and learn how to use the evaluation forms that were developed to follow the two intake protocols (see Appendices G and I).

At the FSU Counseling Center, Dr. Mark Van Lent reviewed the audiotaped SFBT and SCID intake assessments. Dr. Van Lent has received extensive training in psychological assessment and has taught several counseling courses, which have included assessment and interviewing techniques. Furthermore, Dr. Van Lent participated in both the SFBT and SCID-I trainings at the FSU Counseling Center.

The trained raters at WMU and FSU watched the videotapes or listened to the audiotapes during the process by which the sessions were assessed for treatment adherence. Minor suggestions were provided to the research intake counselors as needed based upon the review of their taped research intakes. All intakes were rated as overall adhering to the respective intake protocol by the independent raters.

Following the review of the videotapes or audiotapes and completion of the evaluation forms, the tapes were transcribed and then destroyed. Transcribing was completed by the doctoral students who served as raters and by another graduate student who volunteered her time to gain some experience with research. All students involved in this study satisfactorily passed the online training sessions on research ethics required by WMU. The transcriptions will be retained for at least 3 years in a locked filing cabinet in the principal investigator's office on the WMU and FSU campuses. Participants who completed this study were given a thank-you letter from the student investigator for their involvement.

Counselor Training

SFBT Training

The counselors participated in a 90-minute SFBT training conducted by Dr. Gary Bischof, a professor, licensed marriage and family therapist, and accomplished researcher who has published several articles on the application of SFBT. This training addressed the following areas: (a) basic theoretical formulations of SFBT, (b) development of problems, (c) goals of therapy, (d) conditions for change, and (e) SFBT techniques. This training described and highlighted the rationale and appropriate use of SFBT techniques in the intake assessment session. Each counselor was provided with an SFBT intake interview script (Appendix B). This script prompted the counselor to ask questions and employ techniques at specific points throughout the assessment. The SFBT training made use of SFBT journal articles, textbooks, and training videos.

The SFBT training included an experiential component. This component involved the counselors administering the SFBT intake interview in practice client-counselor role-play dyads. Following this training, the counselors were asked to conduct two role-plays with one of their colleagues. The second role-play was videotaped or audiotaped and submitted to Dr. Bischof for review and evaluation as to whether they had conducted the role-play intake in accord with the established protocol, using the SFBT Evaluation Form (Appendix G) in order to ensure treatment fidelity. Feedback was provided to the counselors regarding their performance and suggestions were made for future administrations. Following successful administration of the final practice intake, the counselors were then cleared to begin administering subsequent SFBT intake interviews.

for the purpose of this study. However, the counselors did not begin administration of the treatment intakes for this study until they had successfully completed both the SFBT and SCID-I trainings. In order to assure treatment adherence, Dr. Bischof and one of the trained raters reviewed each of the SFBT intake interviews at WMU, and Dr. Van Lent reviewed each of the SFBT intakes administered as part of this study at FSU. Dr. Bischof remained available throughout the study to provide additional consultation and supervision, as needed, to the WMU and FSU counselors. A detailed outline of the SFBT training is provided in Appendix H.

SCID Training

The counselors also participated in a 90-minute SCID-I training conducted by Dr. Eric Sauer, a professor, licensed psychologist, clinic director, and accomplished researcher who has published in the area of counseling process and outcome. Dr. Sauer has also taught several graduate-level courses related to psychopathology and the *DSM-IV* criteria for mental disorders. All of the counselors that participated in this study had prior experience conducting intake interviews, and had coursework in psychopathology and psychiatric diagnosis. Due to the fact that the counselors had prior knowledge of psychopathology and psychiatric diagnosis, the SCID-I training did not review these basic concepts. The SCID-I training began with a review of the *SCID User's Guide* (First et al., 2002), which explained all of the conventions of the SCID-I and the special instructions for using the various diagnostic modules. Special attention was given to the overview and screening modules, which were used in this study. Each counselor was provided with a SCID-I intake interview script. This script prompted the counselor to ask specific

questions throughout the interview. Additionally, the counselors were trained using case vignettes. These vignettes were provided so that counselors would have opportunities to practice administering the SCID-I.

The SCID-I training also included an experiential component. This component involved the counselors administering the SCID-I intake interview in practice client-counselor role-play dyads. Following this training, the counselors were asked to conduct two role-plays with one of their colleagues. The second role-play was videotaped or audiotaped and submitted to Dr. Sauer for review and evaluation as to whether they had conducted the role-play intake in accord with the established protocol, using the Evaluation Form for the SCID-I Interview (Appendix I). Feedback was provided to the counselors regarding their performance and suggestions were made for future administrations. Following successful administration of the final practice intake, the counselors were then cleared to begin administering subsequent SCID-I intake interviews for the purpose of this study. In order to assure treatment adherence and consistent with the monitoring of the SFBT intakes, Dr. Bischof and one of the trained raters reviewed each of the SCID-I intake interviews at WMU, and Dr. Van Lent reviewed each of the SCID-I intakes administered at FSU. Dr. Sauer remained available throughout the study to provide additional consultation and supervision, as needed, to the WMU and FSU counselors. A detailed outline of the SCID-I training is provided in Appendix J.

Dependent Measures

The Outcome Questionnaire (OQ45.2)

The Outcome Questionnaire (OQ-45.2; Lambert, Hansen, et al., 1996) is a 45-item instrument that measures clients' current level of distress and is designed to be repeatedly administered at each session during the course of therapy. The OQ-45.2 total score ranges between 0 and 180, with lower scores indicating less symptomology and higher scores indicating greater degrees of symptomology and distress. The OQ-45.2 provides a cutoff score of 63, which identifies scores of 64 or higher as representative of a clinical population, and scores of 62 and below as representative of a nonclinical population.

In regard to face validity, the content of the OQ items is consistent with the nature of symptomatic distress and interpersonal problems reported in a broad spectrum of employee assistance program, outpatient, and inpatient client samples (Lambert et al., 1998). Research indicates that the OQ total scores on the OQ-45.2 have sufficient internal consistency ($r = .93$), as well as adequate 3-week test-retest reliability ($r = .84$). The concurrent validity for the OQ-45 ranges from moderate to high ($r = .50$; $r = .85$) when correlated with similar measures, such as the Symptom Checklist-90-R, General Severity Index, and the Beck Depression Inventory, which are designed to assess psychotherapy outcome (Lambert, Burlingame, et al., 1996; Lambert, Hansen, et al., 1996; Lambert et al., 1998). In addition, OQ-45.2 scores have shown to be responsive to counseling related changes over short periods of time (Vermeersch, Lambert, & Burlingame, 2000). Furthermore, the OQ-45.2 was found to be rather stable in nontreated individuals, while

being sensitive to change in patients undergoing psychotherapy (Lambert et al., 1998; Lambert, Thompson, Andrews, Kadera, & Eriksen, 1996).

The OQ-45.2 is a widely used instrument that has been increasingly utilized in research as well as clinical application since its development in 1994. A recent survey noted that the OQ-45.2 has become the third most frequently used measure of treatment outcome by psychologists in clinical practice (Ellsworth, Lambert, & Johnson, 2006; Hatfield & Ogles, 2004).

Counselor Rating Form–Short Version (CRF-S)

The Counselor Rating Form–Short Version (CRF-S; Corrigan & Schmidt, 1983) was adapted from the original CRF developed by Barak and LaCrosse (1975). The CRF-S is conceptually based on Strong's (1968) hypothesis regarding counselor expertness, attractiveness, and trustworthiness as dimensions of counselor influence.

The CRF-S is a 12-item, 7-point Likert scale, which assesses the client's reaction to the counselor. The CRF-S is anchored by the words "not very" and "very." The endpoint of "not very" is scored a 1, and the other endpoint, "very," is scored a 7. Each subscale consists of four items and is scored by summing the respective items for each of the three. Subscale scores can range from 4 to 28, and a total effectiveness score of 12 to 84. Higher scores on the subscales indicate higher client ratings of the counselor's expertness, attractiveness, or trustworthiness (Corrigan & Schmidt, 1983).

The CRF-S has been and still is one of the most commonly used scales of its type as reflected by the frequency of citation in the counseling literature (Ponterotto & Furlong, 1985). Construct validity for the CRF-S is based on a confirmatory factor

analysis, which provided evidence for a three-factor oblique model that corresponded with the attractiveness, expertness, and trustworthiness dimensions. Internal consistency for the CRF-S total score has been reported as ranging from .82 to .94 with a median of .91 (Corrigan & Schmidt, 1983) to .63 to .89 with a median of .82 in a later validation study (Tryon, 1987). Inter-item reliability has been documented between .84–.93 for the expertness items, .84–.92 for the attractiveness items, and .79–.92 for the trustworthiness items (Corrigan & Schmidt, 1983; Ellingson & Galassi, 1995; Ponterotto & Furlong, 1985; Tracey, Glidden, & Kokotovic, 1988).

Session Evaluation Questionnaire (SEQ)

The Session Evaluation Questionnaire (SEQ; Stiles, 1980; Stiles, Gordon, & Lani, 2002), Form 5, is a self-report measure that lists 21 items in a 7-point bipolar adjective format. The first 11 items assess the depth and smoothness of the session, and begin with the stem “This session was . . .” The SEQ depth index is the mean rating of the following bipolar scales: deep-shallow, full-empty, powerful-weak, valuable-worthless, and special-ordinary. The smoothness index is the mean rating of the following bipolar scales: comfortable-uncomfortable, smooth-rough, easy-difficult, pleasant-unpleasant, and relaxed-tense. Depth indicates whether the participant viewed the session as powerful and valuable or weak and worthless. Additionally, smoothness indicates whether the session was relaxed and comfortable or tense and distressing. Higher scores on these scales represent greater depth and smoothness (Stiles & Snow, 1984).

The second half of the SEQ includes 10 items that assess post-session mood in regard to the dimensions of arousal and positivity. Stiles, Reynolds, Hardy, Rees,

Barkham, and Shapiro (1994) have shown that arousal and positivity are strongly correlated with one another. Additionally, these constructs as measures of mood are likely to be influenced by factors unrelated to the counseling session (Stiles et al., 2002). Construct validity for the SEQ is based on a confirmatory factor analysis, which provided evidence for depth ($\alpha = .87$), smoothness ($\alpha = .93$), positivity ($\alpha = .89$), and arousal ($\alpha = .78$) (Stiles & Snow, 1984).

With respect to internal consistency, the SEQ indexes have reported alpha coefficients of .90 for depth, and .93 for smoothness (Stiles & Snow, 1984). Interestingly, session impact has been positively correlated with helpfulness ratings from both counselors and clients. More specifically, the more helpful a session was perceived, the deeper it was rated to be (Hill et al., 1994). Stiles and Snow reported test-retest reliability estimates of .80 for the SEQ over a 6-week period of time.

Immediate Outcome Rating Scale (IORS)

The Immediate Outcome Rating Scale (IORS) assesses improvement in the presenting problem and overall client functioning. The IORS asks clients to rate statements regarding goal clarity and outcome optimism on a 7-point rating scale, where 7 indicates “Yes, I strongly believe it is true” and 1 indicates “No, I strongly believe it is not true” (Adams et al., 1991).

Adams et al. (1991) developed additional items that accompanied the IORS that explicitly assess “outcome optimism” and “goal clarity.” An initial pool of 45 items theoretically consistent with these concepts as defined by de Shazer’s SFBT approach was generated to measure these two constructs. A panel of senior clinicians, including

de Shazer, reviewed this item pool in order to establish content validity. The clinicians were asked to rate each of the 45 items on a 5-point scale indicating the extent to which they reflected the concepts of outcome optimism and goal clarity. Those items that were scored the highest, either a 4 or a 5, were included on a questionnaire and then administered to a pilot group of clients that were in the initial stages of counseling. The results from this pilot sample indicated a Cronbach alpha reliability of .86 for goal clarity and .81 for outcome optimism at the end of session one. At the end of session two, the reliability for goal clarity and outcome optimism was .76 and .83, respectively.

In regard to the current study, the researchers were unable to run psychometric analyses specific to reliability and validity due to the small number of participants that participated. However, the results from previous studies listed above provide evidence that the assessment measures are reliable and valid.

Verification of Treatment Fidelity

As mentioned in the previous chapter, trained raters at both WMU and FSU reviewed the videotapes and audiotapes of the SFBT and SCID-I intake assessment sessions using the respective evaluation forms to rate treatment assurance. Following the review of the videotapes and audiotapes and completion of the evaluation forms, the tapes were transcribed and then destroyed. Thirty-seven clients consented to participate in this study, of which 30 completed all of the required outcome measures. Of these 30 sessions, a total of 5 were not videotaped or audiotaped due to a variety of reasons. The most common reason was that the clinician had forgotten to begin the audio or videotaping at the outset of the session. All 30 of the sessions that were reviewed passed this evaluation

process. A session was determined to have passed if the clinician stayed true to the intake protocol by asking each question or some close variation of it, and then providing sufficient follow-up questions. The length of time of each of the intake sessions was also recorded, and these data revealed that the average length of the SFBT intake assessment was 20 minutes, and the average for the SCID assessment was 18 minutes.

Null Hypotheses

Hypotheses 1 a–d: There are no statistically significant differences in participants' ratings of the counselor's (a) expertness, (b) trustworthiness, (c) attractiveness, and (d) total effectiveness, between those participants who were administered the SFBT and SCID-I intake assessment, as measured by the CRF-S.

Hypotheses 2 a–d: There are no statistically significant differences in participants' ratings of session (a) depth, (b) smoothness, (c) positivity, and (d) arousal, between those participants who were administered the SFBT and SCID-I intake assessment, as measured by the SEQ.

Hypotheses 3 a–b: There are no statistically significant differences in participants' ratings of (a) outcome optimism, and (b) goal clarity, between participants who were administered the SFBT and SCID-I intake assessment, as measured by the IORS.

Hypothesis 4: There are no statistically significant differences in participants' ratings of current level of distress, between those participants who were administered the SFBT and SCID-I intake assessment, as measured by the OQ-45.2.

Limitations

It is important to consider the limitations of this study before moving forward. First, the majority of the counselors and participants involved in this study were from Caucasian descent. More specifically, all of the counselors and 22 of the 30 participants reported their race/ethnicity as Caucasian. Next, all of the outcome assessments were based exclusively on self-reports of the participants. Be that as it may, each of the instruments used in this study has adequate reliability and validity. Another limitation is that this study did not include specification of the study sample or focus on treatment of a specific mental disorder. All clients seeking individual counseling at CCPS-GR, KZ, and at the FSU Counseling Center were invited to participate in this study regardless of their presenting problem. However, the study did provide some exclusionary criteria. The exclusionary criteria indicated that any client who reported symptoms of a psychotic disorder and/or reported being suicidal or homicidal was not asked to participate. Additionally, any client who was unable to consent to treatment due to a mental impairment was not asked to participate. Last, the study limited participation to adults within the age range of 18-70 years. Although this study did not specify the sample by way of presenting problem or otherwise, it is representative of most intake assessment procedures that do not extensively screen clients.

CHAPTER IV

RESULTS

The present study was designed to assess differences between a Solution-Focused Brief Therapy (SFBT) intake intervention and an intake intervention constructed from the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I; First et al., 2002) on measures of counselor credibility, which encompasses counselor attractiveness, expertness, and trustworthiness as measured by the Counselor Rating Form–Short Version (CRF-S); session depth, smoothness, positivity, and arousal as measured by the Session Evaluation Questionnaire (SEQ); outcome optimism and goal clarity as measured by the Immediate Outcome Rating Scale (IORS); and client’s current level of distress as measure by the Outcome Questionnaire (OQ-45.2). More specifically, the OQ-45.2 was used to assess the difference in participants’ scores from the pre-intake administration and the subsequent administration, which occurred prior to the following counseling session. These differences in scores were then assessed between both treatment groups.

SPSS Software was used to conduct all statistical analyses in this study. *t* tests were conducted on each of the 11 dependent variables, utilizing the mean scores of these variables from the two treatment groups.

Hypotheses Results

Hypotheses 1a–d: There are no statistically significant differences in participants' ratings of the counselor's (a) expertness, (b) trustworthiness, (c) attractiveness, and (d) total effectiveness, between those participants who were administered the SFBT and SCID-I intake assessment, as measured by the CRF-S.

To investigate these hypotheses, a series of two-tailed t tests was conducted based upon the mean scores from both treatment groups. This analysis revealed that there were no statistically significant findings that indicated differences between the SFBT and SCID-I intake assessment on measures of counselor (a) expertness ($t = .22, p < .83$), (b) trustworthiness ($t = .87, p < .39$), (c) attractiveness ($t = .44, p < .67$), or (d) total effectiveness ($t = -.72, p < .48$). Therefore, Hypotheses 1 a–d are retained.

Hypotheses 2 a–d: There are no statistically significant differences in participants' ratings of session (a) depth, (b) smoothness, (c) positivity, and (d) arousal, between those participants who were administered the SFBT and SCID-I intake assessment, as measured by the SEQ.

To investigate these hypotheses, a series of two-tailed t tests was conducted utilizing the mean scores from both treatment groups. This analysis revealed that there were no statistically significant findings that indicated differences between the SFBT and SCID-I intake assessment on measures of session (a) depth ($t = -.56, p < .58$), (b) smoothness ($t = 1.44, p < .16$), (c) positivity ($t = -1.10, p < .28$), or (d) arousal ($t = 1.33, p < .20$). Therefore, Hypotheses 2 a–d are retained.

Hypotheses 3 a–b: There are no statistically significant differences in participants' ratings of (a) outcome optimism, and (b) goal clarity, between participants who were administered the SFBT and SCID-I intake assessment, as measured by the IORS.

To investigate these hypotheses, a series of two-tailed t tests was conducted utilizing the mean scores from both treatment groups. This analysis revealed that there were no statistically significant findings that indicated differences between the SFBT and SCID-I intake assessment on measures of (a) outcome optimism ($t = -1.08, p < .29$), or (b) goal clarity ($t = 1.04, p < .31$). Therefore, Hypotheses 3 a–b are retained.

Hypothesis 4: There are no statistically significant differences in participants' ratings of change in current level of distress, between those participants who were administered the SFBT and SCID-I intake assessment, as measured by the OQ-45.2.

To investigate this hypothesis, a two-tailed t test was conducted utilizing the mean scores from both treatment groups. This analysis revealed that there were no statistically significant findings that indicated differences between the SFBT and SCID-I intake assessment intervention on the measure of current level of distress with respect to change in scores from the pre-intake administration and the following administration prior to the subsequent counseling session, $t = .84, p < .41$. Therefore, Hypothesis 4 is retained. Upon inspection of the OQ-45.2 data it was determined that there were three outliers that contributed to the high amount of variance within this sample of participants. These outliers included change scores of 30 and 44 points, representing a decrease in symptoms of distress, and the final score of 32 points, represented an increase in symptoms of distress. The outliers were retained in the data analysis. Further inspection of this data revealed that, of the participants administered the SFBT intake, only one reported an

increase in distress. This participant's score increased by 2 points between administrations. In comparison, there were 6 participants who received the SCID-I intake that reported an increase in distress between OQ administrations. The mean increase in distress for the 6 was 14.17 points. See Appendix K for graphs of the OQ change scores for those participants in both treatment groups.

The average length of time between the first and second administration of the OQ was recorded. The mean for those administered the SFBT intake was 18.46 days, and 15.33 days for those administered the SCID intake.

Post Hoc Analysis

Hypothesis 4 revealed a large mean difference between male and female participants with respect to the change in OQ-45.2 current level of distress scores between the first and second administration. The mean change for OQ scores from intake to the subsequent counseling session for the grouping of all female participants was 12.69. These 16 female participants received both the SFBT and SCID intake assessments. The mean change for OQ scores from intake to the subsequent counseling session for the grouping of all male participants was 1.00. This grouping also represents participants that received both intake assessments. The female participants reported a much greater reduction in level of distress between the intake and subsequent counseling session than did their male counterparts.

Of the 16 female participants, 10 were administered the SFBT intake assessment and 6 were administered the SCID-I. The mean for the change in OQ scores among the 10 female participants that were administered the SFBT intake was 11.80 with a standard

deviation of 9.34. The mean for the change in OQ scores among the 6 female participants that were administered the SCID intake was 14.16 with a standard deviation of 12.20. To investigate whether there were any differences between these two small groups of female participants based upon the original hypothesis 4, a two-tailed t test was conducted utilizing the mean scores from both treatment groups. This analysis revealed that there were no statistically significant findings that indicated differences between the SFBT and SCID-I intake assessment on the measure of current level of distress with respect to change in scores from the pre-intake administration and the following administration prior to the subsequent counseling session, $t = .44, p < .67$.

Summary

Data in this study were analyzed with using two-tailed t tests. This study proposed a total of 11 null hypotheses, and all of the hypotheses were retained. There were no statistically significant findings that indicated any differences between those participants that received the SFBT and SCID-I intake based upon the 11 variables within the four outcome measures. A post hoc analysis also revealed no statistically significant findings, thus indicating that there were no differences based upon the change in OQ-45.2 change scores between the two administrations, among those female participants that received the SFBT and SCID-I intake assessment. In light of the nonsignificant findings, the data from this study may be utilized in the future in combination with data from similar research studies, consistent with the procedures of a meta-analysis, thus possibly providing a large enough pool of data to more clearly examine the differences between the SFBT and SCID-I intake assessment.

CHAPTER V

DISCUSSION

The Structured Clinical Intake for the *DSM-IV* Axis I Disorders (SCID-I) is one of the most widely used diagnostic interviews, and reflects a “gold standard” in formulating accurate diagnoses (Shear et al., 2000; Spitzer et al., 1992). Not surprisingly, many mental health care agencies and clinics use the SCID-I or some variation of it. The underlying assumption associated with utilization of the SCID-I as an intake assessment is that the objective of the session is to conduct a thorough evaluation of the presenting problem in order to make an appropriate diagnosis in accordance with the *DSM-IV*. The Solution-Focused Brief Therapy (SFBT) intake assessment developed for this study stands in stark contrast to the SCID-I and its primary objective, evaluation of the problem. SFBT is a strength-based model that maintains a positive and future-oriented focus. This model is deliberate in its focus on initiating and maintaining discussions of strengths, resources, and solutions as opposed to problems (Walter & Peller, 1992).

Since its inception, Solution-Focused Brief Therapy (SFBT) has grown in popularity with mostly anecdotal evidence supporting its efficacy. A review of the SFBT outcome literature revealed that it has been implemented and studied in university clinics, mental health settings, residential treatment centers, prisons, schools, and private practice (De Jong & Hopwood, 1996; Eakes et al., 1997; LaFountain & Garner, 1996; Lambert et al., 1998; Lindforss & Magnusson, 1997; Triantafillou, 1997; Zimmerman et al., 1996).

Notwithstanding, SFBT is still in the preliminary stages of building empirical evidence for its efficacy, through rigorous outcome studies (De Jong & Hopwood, 1996; Gingerich & Eisengart, 2000).

Within the current SFBT research literature, relatively little is known about the effectiveness of SFBT as related to the intake assessment. This study investigated the relative effects of an SFBT and SCID-I intake assessment intervention on client's evaluation of counselor credibility, which includes counselor attractiveness, expertness, trustworthiness, and total effectiveness; session depth, smoothness, positivity, and arousal; outcome optimism and goal clarity; and client's current level of distress. The purpose of this study was to add to the SFBT outcome literature, as well as contribute to the literature pertaining to the early stages of therapy.

Summary of Methodology

This study recruited adult clients seeking individual counseling to participate in this research. The clients were recruited at two Midwestern psychology training clinics and a university counseling center. The counselors that administered the study intake assessment protocols were employed at these same three centers. Prior to data collection, each of the counselors participated in the SFBT and SCID-I intake assessment trainings. Data in this study were obtained from a total of 30 participants. This study employed a mean comparison design in which participants' outcome scores on the SFBT and SCID-I intakes were assessed. Participants were randomly assigned to either treatment A (SFBT intake) or treatment B (SCID-I intake). The outcome scores came from four separate assessments: the Session Evaluation Questionnaire (SEQ; Stiles, 1980; Stiles et al.,

2002), which measured session depth, smoothness, positivity and arousal; Counselor Rating Form–Short Version (CRF-S; Corrigan & Schmidt, 1983), which assessed counselor expertness, trustworthiness, attractiveness, and total effectiveness; Immediate Outcome Rating Scale (IORS; Adams et al., 1991), which assessed outcome optimism and goal clarity; and the Outcome Questionnaire (OQ-45.2; Lambert, Hansen, et al., 1996) which assessed current level of distress. A series of *t* tests was conducted on each of these 11 variables.

Findings and Interpretations

This study revealed no statistically significant differences between the SFBT and SCID-I intake assessment intervention on the various dependent variables in this research. Although there were no significant findings, a few results were noteworthy. First, the mean scores from the SFBT and SCID-I intake assessment groups on the OQ-45 outcome variable, which measured the difference in OQ scores from the pre-intake assessment and subsequent administration, were 9.67 and 4.80, respectively, thus indicating that the average reduction in current level of distress was slightly more than twice as great in the SFBT group as in the SCID-I group. Interestingly, the reliable change index, RCI, for the OQ indicates that a change of 15 points or greater indicates that the client's improvement is statistically significant and reliable (Lambert, Hansen, et al., 1996). Although this mean difference is interesting in light of the small number of participants, it ultimately proved to be nonsignificant. It is possible that this result is due to a small number of participants and a large amount of variance in OQ scores within both groups.

Another explanation for this nonsignificant finding as well as the others in this study is the influence of common factors. To date, there is less than modest evidence to suggest the supremacy of one treatment modality over another (Ahn & Wampold, 2001; Lambert, 1992; Lambert & Ogles, 2004; Wampold, 2001). The common finding that there are no significant differences in the outcome of therapy for clients that have participated in diverse psychotherapies suggests that it is possible that distinct therapies embody common factors, or what might also be called “nonspecific” or “general” factors, that are remedial. Hubble, Duncan, and Miller (1999) have identified four specific common factors: (a) client/extratherapeutic factors; (b) relationship factors; (c) placebo, hope, and expectancy; and (d) model/technique factors. A brief description of these four factors follows below.

The common factors research literature suggests that client factors are the most powerful contributor to outcome in therapy (Hubble et al., 1999). Client/Extratherapeutic factors consist of characteristics or qualities of the client such as (a) strengths and fortitude, (b) resources and social support, (c) level of motivation and perseverance, (d) commitment to change, (e) religious/spiritual faith, and (f) fortuitous events (Hubble et al., 1999; Sprenkle & Blow, 2004). Factors such as client strengths, resources, motivation for change, and faith are consistent and closely aligned with SFBT and the interventions specific to the SFBT intake assessment. Although the SCID-I does not assess these client characteristics to the same extent of the SFBT assessment, these participants still embody these same qualities as their counterparts in the SFBT treatment group.

The relationship factors between the client and therapist are in essence the therapeutic alliance. Therapeutic alliance has been defined as the mutual product of the therapist and the client together examining the work of therapy (Orlinsky, Ronnestad, & Willutzki, 2004). This particular factor may not have had a significant impact on the nonsignificant findings in this study due to the fact that there was not much of a relationship between the counselor and client prior to the administration of the outcome measures. As previously noted, the average length of the SFBT intake assessment was 20 minutes, and the average for the SCID-I assessment was 18 minutes.

The placebo factors have been defined as the portion of outcome that can be attributed to the client's hope and expectancy that treatment will produce a desirable outcome. Additionally, a client must firmly believe in the credibility of the treatment's rationale in order for hope and positive expectancy to be generated (Snyder, Michael, & Cheavens, 1999). This particular factor is interesting because clients come to counseling with diverse expectations as to how the first counseling session or intake assessment will be conducted, and in turn how it will help them reduce and hopefully eliminate their current symptoms of psychological distress. For example, some clients with an extensive history of psychotherapy treatment may come to a new counseling situation with the expectancy that their therapist will comprehensively assess their various mental health problems, and that this will be helpful because it allows them to vent about problematic situations. On the other hand, clients may come to counseling with a strong desire to change their current situation and be more focused on gaining assistance with making changes in the present and future than exploring the problems of the past. These two

diverse client situations depict scenarios in which some individuals may prefer the process of the SCID-I or SFBT intake based upon counseling expectations.

In general, the model/technique factors are therapeutic and healing procedures. More specifically, a model constitutes a collection of beliefs about what is needed to bring about change with a particular client in a particular situation. Techniques are thought to be the actions that are extensions of the beliefs from the theory (Ogles, Anderson, & Lunnen, 1999). The counselors involved in this study reported their theoretical orientations, and no counselor reported a strict adherence to SFBT or an orientation consistent with the SCID-I intake. Therefore, a study of this nature could benefit from this factor by utilizing counselors that are extensively trained in SFBT and the SCID-I intake.

Yet another explanation for this nonsignificant finding may be found within the design. The design of this study came from the small chunk model of psychotherapy research (Greenberg & Pinsof, 1986). This model describes how research can be conducted at immediate outcomes or micro-outcomes, and can be meaningfully assessed after any session, or intermittently over the course of treatment (DeRubeis & Feeley, 1990; Gale & Newfield, 1992; Rice & Greenberg, 1984). The participants in this study were asked to respond to all but one of the outcome measures immediately following the SFBT or SCID-I portion of the intake. The final measure was the second administration of the OQ, which was given to participants when they returned to counseling following the intake. The design of this study was such that participants experienced only a small portion of the psychotherapy process prior to data collection. Therefore, it is possible that

differences between these two intake assessments are not as easily detected at this point in psychotherapy versus points later in treatment.

The second noteworthy finding was also related to the OQ-45. The mean change for OQ scores from intake to the subsequent counseling session for the grouping of all female participants was 12.69. These 16 female participants received both the SFBT and SCID intake assessments. The female participants from both treatment groups were analyzed using a two-tailed t test on the OQ-45 variable. The result of this t test was also nonsignificant, indicating no differences between the females in the SFBT and SCID-I groups in regard to change in their OQ scores, $t = .44$, $p < .67$. The mean score for the female participants in the SFBT group ($N = 10$) was 11.80 with a standard deviation of 9.34. The mean for the females in the SCID-I group ($N = 6$) was 14.16 with a standard deviation of 12.20. This particular nonsignificant finding may also be attributed to common factors as discussed above. Additionally, the data were collected very early in the process of treatment and this may have also influenced the nonsignificant finding. Further studies dedicated to gender differences in this line of research may help to illuminate the differences between the female and male clients' experience within both of these intakes. Future studies might also consider controlling for gender based upon this result.

Limitations

This section will address the limitations related to the design, methodology, and findings documented in this study. First, the results of this study were based solely on self-reports from the client participants. Self-report instruments are vulnerable to

dishonest responses, and some participants may choose to respond in a haphazard fashion. Although each of the dependent variables were self-report instruments, each has sufficient reliability and validity, and the degree of measurement error based upon the nature of the instruments is foreseen to be no greater than in other studies that have used similar self-report measures.

Next, the sample size was small, 30 participants, and predominantly Caucasian. The small sample size hindered the ability to detect differences statistically. The findings of this study came from a rather homogenous participant population based upon racial/ethnic demographics. A total of 22 of the 30 participants reported Caucasian/White as their race. Thus, generalizations made from these results may be most appropriate for clients from racial backgrounds similar to those in this study. Furthermore, all six of the counselors that conducted the intakes for this study reported Caucasian/White as their race. The lack of diversity within the counselor population further limits the generalizations that can be made from this particular study.

Third, this study did not include extensive specification of the participant population or focus on the assessment of a specific mental disorder. All clients seeking individual counseling at CCPS-GR, KZ, and the FSU Counseling Center were invited to participate in this study regardless of their presenting problem. Nonetheless, the study did provide some exclusionary criteria. The exclusionary criteria indicated that any client who reported symptoms of a psychotic disorder and/or reported being suicidal or homicidal was not asked to participate. Additionally, any client who was unable to consent to treatment due to a mental impairment was not asked to participate. Although this study did not limit the participant sample by focusing on one specific mental disorder

or presenting problem, it is representative of most intake assessment procedures that do not extensively screen clients.

Fourth, the SFBT intake assessment utilized in this study was constructed from the stages of solution building as described in the work of De Jong and Berg (2002), de Shazer (1988), de Shazer et al. (1986), and Lipchick and de Shazer (1986). Although this intake assessment employed several SFBT interventions or core conditions, it may not have fully reflected the SFBT model. For example, this assessment did not use the consulting break intervention due to time and procedural limitations.

Fifth, the final data collection site, the FSU Counseling Center, provides services to a different population as compared to the two WMU CCPS sites. The FSU Counseling Center provides counseling services exclusively to currently enrolled university students, whereas the client base for CCPS-GR consists primarily of community referrals and court-mandated clients, and for CCPS-KZ consists of community referrals in addition to some WMU students.

Sixth, the process by which treatment adherence was established was not consistent within each data set. More specifically, five intakes were not videotaped or audiotaped due to a variety of reasons. In addition, interrater reliability was not utilized at FSU as a method to more rigorously verify adherence to the intake protocols.

Last, following the SFBT and SCID-I intake assessment interventions, the counselor continued with the standard intake protocol during the remainder of the session. As previously noted, the average length of the SFBT intake intervention was 20 minutes, and the average for the SCID-I intake intervention was 18 minutes. The

inclusion of the standard intake protocol following the SFBT and SCID-I intakes may represent a confounding variable with respect to the final administration of the OQ-45.

Recommendations for Future Research

The following are recommendations for future research.

1. Future researchers should consider a replication of the present study or a version of the present study that utilizes a larger sample and a more specific sample population in regard to presenting problem. For example, the sample population could be limited to participants that meet the criteria for a particular mood or anxiety disorder.
2. Researchers are encouraged to consider replicating the present study utilizing client populations that are more racially and ethnically diverse.
3. This study provided trainings to the counselors that conducted the SFBT and SCID-I intake protocols. These trainings were not extensive but provided the counselors with a basic understanding of the SFBT and SCID-I intake interviews. Future researchers could provide more in-depth trainings of both intakes. This SFBT training may utilize a more extensive discussion of theoretical formulations, as well as a thorough explanation of the appropriate use or timing of specific techniques. The SCID-I training could include a discussion of all modules and the requisite experiential trainings.
4. Future research would benefit from the use of more robust assessments that evaluate concepts such as hopefulness, optimism, goal clarity, and other constructs consistent with SFBT.
5. This study gathered participants from three separate counseling centers. One of the three centers provided services exclusively to university students, which was in

contrast to the other two sites. Therefore, future research is recommended to collect data from one treatment setting, or combine data from only similar treatment settings.

6. This study relied exclusively upon self-report instruments for data collection. Future researchers are recommended to utilize other observational reports from counselors and family members who are knowledgeable of the participant and his or her behavior.

7. The average length of the SFBT and SCID-I intake assessment interventions in this particular study were 20 minutes and 18 minutes, respectively. Future research may benefit from extending these intake assessments to the more traditional 50-minute therapy hour. Furthermore, this may result in a more pronounced difference between the two intakes, and thus participants may document more extensive differences between the two assessments on measures such as those utilized in this study.

Implications

This study proposed a total of 11 null hypotheses, and all of the hypotheses were retained. There were no statistically significant findings that indicated any differences between those participants that received the SFBT and SCID-I intake based upon the 11 variables within the four outcome measures. These findings suggest that the SFBT intake is as effective as the SCID-I intake based upon the dependent variables in this study. This is particularly noteworthy because the SCID-I is one of the most widely used diagnostic interviews.

In regard to clinical significance, the findings of this study support the utility of the SFBT intake assessment as an intervention at the first counseling session. Counseling

centers and mental health agencies may wish to employ this SFBT intake intervention in order to provide consistency between the intake and future counseling sessions administered from an SFBT framework. At many counseling centers, therapists occasionally administer the intake assessment and then refer the client to another therapist within the same center. In these situations it would be particularly important to provide the client with a consistent form of therapy from the onset and throughout counseling.

The SFBT intake assessment used in this study represents a strategically structured intake that incorporates many SFBT interventions. This assessment includes the following interventions; Pre-Treatment Change Question, Complimenting, Miracle Question, Exception Question or Coping Question, Scaling Question, and Identification of Client Strengths and Resources. Mental health professionals and counseling centers that operate from an SFBT theoretical orientation are encouraged to incorporate this SFBT assessment into their intake protocol, in order to provide consistency in treatment starting with the intake.

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Appendix A
WMU CCPS Intake Interview

Intake Interview Summary

I. Presenting Problem or Concern

- Clear statement of the presenting problem.
- How long has problem existed?
- What have they tried to alleviate problem or cope?

II. Expectations for Counseling

- What do they want to get out of counseling?

III. Current Situation

- Do they have a partner/significant other?
- Have they ever been married/separated/divorces?
- Do they have children?
- Who do they live with?
- Supports/social life?

- Recent losses?
- Employment (where, how long, full or part-time)?
- School?

IV. Family Background

- Parents married, divorced, single?
- Relationship with parents?
- Any siblings?
- Relationship with siblings?
- How would they describe childhood?
- Move a lot while growing up?
- Substance abuse in family of origin?
- Any physical/verbal/sexual abuse in family of origin or any other time in life?

V. Relevant Medical History

- Current medications, dosage, how long, who prescribed?

- Closed head injury/seizures?
- Headaches/stomach aches?
- Any other medical concerns?
- Eating/sleeping difficulties?
- Weight change (5 lbs or more in past 6 months)?
- Substance abuse?

VI. Relevant Psychological History

- Previous hospitalizations?
- Family history of mental illness?
- Prior counseling (where, when, beneficial)?
- If prior counseling, what liked/not liked?
- Suicidality (past/present thoughts, plans, attempts)?

VII. Recommendations

- Gender preference?
- Times available?

Revised 5/04 (mf)

Appendix B
SFBT Intake Interview

Solution-Focused Brief Therapy (SFBT) Intake Interview

I. To begin interview:

Tell me, how can I be helpful to you today?

Or, What would you find helpful to talk about today?

- Allow client to explain their presenting problems/concerns.
- Try to highlight or make a mental note of any exceptions to the client's problems/concerns – when is the problem not a problem or less of a problem.
- Try to avoid asking questions about the details of the problem, such as the nature or etiology of the problem.

II. Pre-Treatment Change Question:

Many times people notice in between the time they make the appointment for counseling and attending the first intake session that things have already changed for the better. What have you noticed about your situation?

- If the client responds with positive changes that occurred during this time, follow up by asking – **Do these changes relate to the reason why you have come to counseling?**
- **Are these changes that you would like to see happen more frequently in your life?**
- **What did you do to help bring about these changes?**

III. Complimenting:

How is it that you decided it was important for you to make this appointment and follow through with showing up and participating? What does that say about you as a person?

- Allowing the client to reflect upon the importance of coming to counseling and any positive compliments that she/he might pay herself/himself.
- Listen for any particular strengths/resources.

IV. Miracle Question:

Now I am going to ask you a strange question (pause)... Suppose that you are sleeping tonight and while you are sleeping, a MIRACLE happens. The miracle is that the problems that have brought you here have been SOLVED.

However, because you were sleeping you were unaware this miracle happened. So, when you wake up tomorrow morning, what will be different that will tell you that this miracle has happened, and the problems have been solved?

- Ask client to comment on specific things he/she will be doing differently after the miracle has happened.
- Encourage client to provide further details by saying, “**What else will be different.**”
- Ask client, “**What will your (spouse, partner, friend) notice different about you following this miracle?**”
- Encourage client to tell you what they will be doing instead of what they won’t be doing.
- Try to establish tangible, behavioral, and achievable goals for therapy.

V. Exception Question:

Could you tell me about any times in the last couple of weeks when the problem did not happen, or at least, was a little less severe? Maybe some times when at least some of what you described after the miracle was actually occurring for you?

- If client identifies an exception, then ask for details about it. Ask client, **what is different about those times when the exception is occurring?**
- Ask questions about who, what, when, and where when exploring these exceptions.
- Listen for any client strengths/resources.

Coping Question:

- If a client is unable to identify a recent or past exception, then ask, **how is it that you have been able to cope and keep this problem from getting any worse than it already is?**
- Encourage client to do more of what works.

VI. Scaling Question:

In regard to your motivation to solve this problem, where would you say you are on a scale of 0 to 10, where 10 is the highest level of motivation and 0 is the lowest level of motivation, where would you say you are right now?

- **What do you think would need to happen to help you move one number closer to 10 (for example from a 5 to a 6)?**
- Encourage client to do more of those things he/she thinks would increase their level of motivation.

VII. To end interview:

Recap with client the strengths/resources that they mentioned during the interview, or some of the strengths/resources you think they hold.

Compliment the client on using their strengths/resources. Mention the utility of these strengths/resources in working toward their desired goals.

- Are there any other strengths or resources that you have that we have not talked about?**

Appendix C

SCID-I Intake Interview: Overview and SCID Screening Module

OVERVIEW

I'm going to be asking you about problems or difficulties you may have had, and I'll be making some notes as we go along. Do you have any questions before we begin?

DEMOGRAPHIC DATA

	SEX:	1 male 2 female	PS123
What's your date of birth?	DOB:	____ _ AGE ____ mon day year	PS124 PS125
Are you married?	MARITAL STATUS (most recent):	1 married or living with someone as if married 2 widowed 3 divorced or annulled 4 separated 5 never married	PS126
IF NO: Were you ever?			
Any children? (What are their ages?)			
IF YES: How many?			
Where do you live			
Who do you live with?			

EDUCATION AND WORK HISTORY

How far did you get in school?	EDUCATION:	1 grade 6 or less 2 grade 7 to 12 (without graduating high school) 3 graduated high school or high school equivalent 4 part college 5 graduated 2 year college 6 graduated 4 year college 7 part graduate/professional school 8 completed graduate/ professional school	PS127
IF FAILED TO COMPLETE A PROGRAM IN WHICH THEY WERE ENROLLED: Why didn't you finish?			
What kind of work do you do? (Do you work outside of your home?)			

SCID-I/P (W/PsyScr) (for DSM-IV-TR)

(NOV 2002)

Overview ii

Are you working now?

→ IF YES: How long have you worked there?

IF LESS THAN 6 MONTHS: Why did you leave your last job?

Have you always done that kind of work?

→ IF NO: Why is that? What kind of work have you done?

How are you supporting yourself now?

IF UNKNOWN: Has there ever been a period of time when you were unable to work or go to school?

IF YES: Why was that?

OVERVIEW OF PRESENT ILLNESS

IF UNKNOWN: Have you been in any kind of treatment in the past month

CURRENT TREATMENT STATUS (PAST MONTH):

- 1 - Current inpatient (including residential treatment)
- 2 - Current outpatient
- 3 - Other (e.g., 12-step program)
- 4 - No current treatment

PS128

IF CURRENTLY IN TREATMENT:

DATE ADMITTED TO INPATIENT OR OUTPATIENT FACILITY FOR PRESENT ILLNESS

Number of weeks since admission to facility

- 1 < 1 week
- 2 1-4 weeks
- 3 > 4 weeks

PS129

When did you come to the (hospital, clinic?)

**CHIEF COMPLAINT
AND DESCRIPTION OF
PRESENTING PROBLEM**

What led to your coming here (this time)?
(What's the major problem you've been having trouble with?)

IF DOES NOT GIVE DETAILS OF PRESENTING PROBLEM:

Tell me more about that. (What do you mean by . . .?)

SCID-I/P (W/PsyScr) (for DSM-IV-TR)

(NOV 2002)

Overview iii

**ONSET OF PRESENT ILLNESS
OR EXACERBATION**

When did this begin? (When did you first notice that something was wrong?)

When were you last feeling OK (your usual self)?

NEW SXS OR RECURRENCE

Is this something new or a return of something you had before?

(What made you come for help now?)

**ENVIRONMENTAL CONTEXT AND POSSIBLE
PRECIPITANTS OF PRESENT ILLNESS OR
EXACERBATION**
(USE THIS INFORMATION FOR CODING AXIS IV.)

What was going on in your life when this began?

Did anything happen or change just before all this started? (Do you think this had anything to do with your [PRESENT ILLNESS]?)

**COURSE OF PRESENT ILLNESS
OR EXACERBATION**

After it started, what happened next? (Did other things start to bother you?)

Since this began, when have you felt the worst?

IF MORE THAN A YEAR AGO: In the last year, when have you felt the worst?

SCID-I/P (W/PsyScr) (for DSM-IV-TR)

(NOV 2002)

Overview iv

TREATMENT HISTORY

When was the first time you saw someone for emotional or psychiatric problems? (What was that for? What treatment(s) did you get? What medications?

What about treatment for drugs or alcohol?

(THE LIFE CHART ON PAGE vi OF OVERVIEW MAY BE USED TO DOCUMENT A COMPLICATED HISTORY OF PSYCHOPATHOLOGY AND TREATMENT)

Have you ever been a patient in a psychiatric hospital?

Number of previous hospitalizations
(Do not include transfers)

0

1

2

3

4

5 (or
more)

PS130

IF YES: What was that for? (How many times?)

IF GIVES AN INADEQUATE ANSWER, CHALLENGE GENTLY:
e.g. Wasn't there something else?
People don't usually go to psychiatric hospitals just because they are
(TIRED / NERVOUS / OWN WORDS)

Have you ever been in a hospital for treatment of a medical problem?

IF YES: What was that for?

OTHER CURRENT PROBLEMS

Have you had any other problems in the last month?

What's your mood been like?

How has your physical health been? (Have you had any medical problems?) (USE THIS INFORMATION TO CODE AXIS III)

SCID-I/P (W/PsyScr) (for DSM-IV-TR)

(NOV 2002)

Overview v

Do you take any medication or vitamins (other than those you've already told me about?)

IF YES: How much and how often do you take (MEDICATION)? (Has there been any change in the amount you have been taking?)

How much have you been drinking (alcohol) (in the past month)? Have you been taking any drugs (in the past month)? (What about marijuana, cocaine, other street drugs?)

CURRENT SOCIAL FUNCTIONING

How have you been spending your free time?

Who do you spend time with?

MOST LIKELY CURRENT DIAGNOSIS:**DIAGNOSES THAT NEED TO BE RULED OUT:**

LIFE CHART

[illegible]

RETURN TO OVERVIEW PAGE iv, OTHER CURRENT PROBLEMS

SCID SCREENING MODULE (OPTIONAL)

Now I want to ask you some more specific questions about problems you may have had. We'll go into more detail about them later.

RESPOND TO POSITIVE RESPONSES WITH: We'll talk more about that later.

1. Has there been any time in your life when you had five or more drinks (beer, wine, or liquor) on one occasion?	1 CIRCLE "NO" ON E. 1	2 CIRCLE "YES" ON E. 1	3	S1
2. Have you ever used street drugs?	1 CIRCLE "NO" ON E. 9	2 CIRCLE "YES" ON E. 9	3	S2
3. Have you ever gotten "hooked" on a prescribed medicine or taken a lot more of it than you were supposed to?	1 CIRCLE "NO" ON E. 9	2 CIRCLE "YES" ON E. 9	3	S3
4. Have you ever had a panic attack, when you suddenly felt frightened or suddenly developed a lot of physical symptoms?	1 CIRCLE "NO" ON F. 1	2 CIRCLE "YES" ON F. 1	3	S4
5. Were you ever afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains?	1 CIRCLE "NO" ON F. 7	2 CIRCLE "YES" ON F. 7	3	S5
6. Is there anything that you have been afraid to do or felt uncomfortable doing in front of other people, like speaking, eating or writing?	1 CIRCLE "NO" ON F. 11	2 CIRCLE "YES" ON F. 11	3	S6
7. Are there any other things that you have been especially afraid of, like flying, seeing blood, getting a shot, heights, closed places, or certain kinds of animals or insects?	1 CIRCLE "NO" ON F. 16	2 CIRCLE "YES" ON F. 16	3	S7

1=not present

2=unsure or equivocal

3=present

8. Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them?

1	2	3	
CIRCLE "NO" ON F. 20	CIRCLE "YES" ON F. 20		S8

9. Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number, or checking something several times to make sure that you'd done it right?

1	2	3	
CIRCLE "NO" ON F. 21	CIRCLE "YES" ON F. 21		S9

10. In the last six months, have you been particularly nervous or anxious?

1	2	3	
CIRCLE "NO" ON F. 31	CIRCLE "YES" ON F. 31		S10

11. Have you ever had a time when you weighed much less than other people thought you ought to weigh?

1	2	3	
CIRCLE "NO" ON H. 1	CIRCLE "YES" ON H. 1		S11

12. Have you often had times when your eating was out of control?

1	2	3	
CIRCLE "NO" ON H. 4	CIRCLE "YES" ON H. 4		S12

1=not present

2=unsure or equivocal

3=present

Appendix D
Recruitment Script

Recruitment Script

The following script will be read to potential participants by intake workers/counselors following completion of the intake interview paperwork.

“I would like to invite you to participate in a study that aims to learn more about how clients experience and react to the intake interview, as well as the therapeutic benefits of this interview. If you choose to participate you will be administered one of two different intake interviews. In one interview you will be asked questions that emphasize your strengths and resources, and the other interview places an emphasis on assessment of current symptoms related to your presenting problem. This research is being conducted by Christopher Richmond, MA. and Dr. Alan Hovestadt, Ed.D. Please take a moment to read over this consent form and consider whether or not you would be willing to participate. If you are willing to participate, please sign both copies of the consent document and return one to the drop box in the reception area before you leave today. If you prefer not to participate, you may return both unsigned copies to the box. Please let me know if you have any questions or concerns.”

Appendix E
Consent Forms

Western Michigan University
Department of Counselor Education & Counseling Psychology
Principal Investigator: Alan J. Hovestadt, Ed.D.
Student Investigator: Christopher Richmond, M.A.

You have been invited to participate in a research project entitled "A Study of Intake and Assessment in Solution-Focused Brief Therapy." This research is intended to assess the therapeutic impact and the client's experience and reaction to the intake interview. This project is Christopher Richmond's dissertation project.

You will be exposed to one of two different intake interviews. You will be assigned to one of the two interviews through a process of random assignment. The standard intake procedures differ from the research intake procedures in regard to the assessment of the presenting problem. Additionally, participation in this research would include completion of three outcome assessment measures, whereas the standard intake protocol does not include these measures. If you choose to participate, the first portion of your interview will be videotaped for treatment assurance purposes. These videotapes will be transcribed and then destroyed.

You will be asked to complete a survey packet containing three questionnaires. We anticipate that these will take you 10-15 minutes to complete. Some questions will ask you about your personal reactions and feelings about the intake interview; others will ask about your reactions to your counselor. The survey packet will be given to you during a break in the intake interview. During that break, your counselor will leave the counseling room and allow you to complete the assessments in private. Once the survey packet has been completed it can be delivered to the research box located at the reception area.

We are also asking your permission to access your clinical record to gather demographic information and obtain your overall scores on the Outcome Questionnaire (OQ). All adult clients at the Center for Counseling and Psychological Services at Grand Rapids (CCPS-GR) and at Kalamazoo (CCPS-KZ) are asked to complete the OQ as part of their regular therapy. The OQ is used to measure client progress in therapy and is administered at the initial appointment and before the first counseling session. If you grant permission for the researchers to access your clinical record, we will do so only for the purposes of recording demographic information and your OQ scores. Information concerning the nature or content of your discussions with your counselor will not be accessed.

The information gathered in this study intends to add to the counseling literature and may serve to benefit future clients, students, and counselors by advancing clinical training and practice. However, we do not anticipate any immediate benefits to you. The time it takes to respond to the assessments is the only perceived inconvenience or risk to you.

Your participation in this study is entirely voluntary and you may refuse to participate at any time or refuse to answer any questions without prejudice, penalty, or risk of any loss

of services. You may continue to be seen as a client in the Center regardless of whether or not you choose to participate in this research. Because your participation is confidential, only the researchers will have access to your surveys. The information gathered for this study will be kept separate from your clinical file in a secure and confidential location. The research data will be retained for at least three years in a locked filing cabinet in the Principal Investigator's office on the WMU Campus. Please be aware that your counselors will not have access to the assessments that you will complete as part of this study. Videotapes will be transcribed and the transcriptions will be maintained for at least three years in a locked filing cabinet in the Principal Investigator's office. The researchers will be the only individuals to have access to the transcriptions. Additionally, any information gathered in this study used in future publications would not identify you as a participant in any way.

We anticipate minimal physical or emotional risk to you as a result of your participation in this study. One possible risk or inconvenience is the time it takes to respond to the assessments. Additionally, some assessment questions may elicit negative feelings about yourself, your counselor, or the intake session. If you experience any uncomfortable feelings or thoughts, we invite you to speak with your counselor or the CCPS-GR or CCPS-KZ Director. In regard to the two intake assessments, the only identified limit or cost to you is the additional time it will take to complete the interview.

If you have any questions or concerns about this study, you may contact either Christopher Richmond at (785) 842-4729 or Dr. Alan Hovestadt at (269) 387-5117. You may also contact the chair of the Human Subjects Institutional Review Board at (269) 387-8293 or the vice president for research at (269) 387-8298 with any concerns that you have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old.

Your signature below indicates that you have read and/or had explained to you the purpose and requirements of the study and that you agree to participate.

Signature

Date

Consent obtained by: _____

initials of researcher

Date

Ferris State University
University Counseling Center
Principal Investigator: Christopher Richmond, M.A.

You have been invited to participate in a research project entitled "A Study of Intake and Assessment in Solution-Focused Brief Therapy." This research is intended to assess the therapeutic impact and the client's experience and reaction to the intake interview. This project is Christopher Richmond's dissertation project.

You will be exposed to one of two different intake interviews. You will be assigned to one of the two interviews through a process of random assignment. The standard intake procedures differ from the research intake procedures in regard to the assessment of the presenting problem. Additionally, participation in this research would include completion of four outcome assessment measures, whereas the standard intake protocol does not include these measures. If you choose to participate, the first portion of your interview will be audiotaped for treatment assurance purposes. These audiotapes will be transcribed and then destroyed.

We anticipate that these assessment measures will take you 10-15 minutes to complete. Some questions will ask you about your personal reactions and feelings about the intake interview; others will ask about your reactions to your counselor. The survey packet will be given to you during a break in the intake interview. During that break, you will be asked to complete the assessments in private in the waiting room area. Once the survey packet has been completed it can be delivered to the research box located at the reception area. When you return for your first counseling session following the intake interview you will be asked to complete the final assessment measure. This final assessment will be administered prior to the counseling session.

We are also asking your permission to access your clinical record to gather demographic information. If you grant permission for the researchers to access your clinical record, we will do so only for the purposes of recording demographic information. Information concerning the nature or content of your discussions with your counselor will not be accessed.

The information gathered in this study intends to add to the counseling literature and may serve to benefit future clients, students, and counselors by advancing clinical training and practice. However, we do not anticipate any immediate benefits to you. The time it takes to respond to the assessments is the only perceived inconvenience or risk to you.

Your participation in this study is entirely voluntary and you may refuse to participate at any time or refuse to answer any questions without prejudice, penalty, or risk of any loss of benefits or services. You may continue to be seen as a client in the Center regardless of whether or not you choose to participate in this research. Because your participation is

confidential, only the researchers will have access to your surveys. The information gathered for this study will be kept separate from your clinical file in a secure and confidential location. The research data will be retained for at least three years in a locked filing cabinet in the Responsible Project Investigator's office on the FSU Campus. Please be aware that your counselor will not have access to the assessments that you will complete as part of this study. Audiotapes will be transcribed and the transcriptions will be maintained for at least three years in a locked filing cabinet in the Principal Investigator's office. The researchers will be the only individuals to have access to the transcriptions. Additionally, any information gathered in this study used in future publications would not identify you as a participant in any way. Your privacy will be protected to the maximum extent allowable by law.

We anticipate minimal physical or emotional risk to you as a result of your participation in this study. One possible risk or inconvenience is the time it takes to respond to the assessments. Additionally, some assessment questions may elicit negative feelings about yourself, your counselor, or the intake session. If you experience any uncomfortable feelings or thoughts, we invite you to speak with your counselor.

If you have any questions or concerns about this study, you may contact Christopher Richmond at (231) 842-4729. You may also contact the chair of the Human Subjects Institutional Review Board, Dr. Connie Meinholdt, at (231) 591-2759 with any concerns that you have.

Your signature below indicates that you have read and/or had explained to you the purpose and requirements of the study and that you agree to participate.

Signature

Date

Consent obtained by: _____
initials of researcher

Date

Appendix F

Survey Packet Instructions and Outcome Measures

Dear Research Participant,

This survey packet includes three questionnaires concerning your experiences and reactions to the intake interview. Please read the directions for each questionnaire before responding to it. Please complete all items for each questionnaire. When you have completed the questionnaires please put them back in the envelope and return it to the research drop-box located at the reception desk. Let the receptionist know if you have any questions or concerns. If so, he/she will contact one of the researchers so that you may speak to them. Please refrain from putting any identifying information on the survey packet and the outcome measures.

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name: _____ Age: _____ yrs.
 Sex
 ID# _____ M ☐ F ☐

Session # _____ Date ____/____/____

	Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	DO NOT MARK BELOW		
1. I get along well with others.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
2. I tire quickly.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
3. I feel no interest in things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
4. I feel stressed at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
5. I blame myself for things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
6. I feel irritated.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
7. I feel unhappy in my marriage/significant relationship.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
8. I have thoughts of ending my life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
9. I feel weak.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
10. I feel fearful.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
12. I find my work/school satisfying.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
13. I am a happy person.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
14. I work/study too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
15. I feel worthless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
16. I am concerned about family troubles.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
17. I have an unfulfilling sex life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
18. I feel lonely.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
19. I have frequent arguments.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
20. I feel loved and wanted.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
21. I enjoy my spare time.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
22. I have difficulty concentrating.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
23. I feel hopeless about the future.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
24. I like myself.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
25. Disturbing thoughts come into my mind that I cannot get rid of.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
27. I have an upset stomach.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
28. I am not working/studying as well as I used to.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
29. My heart pounds too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
30. I have trouble getting along with friends and close acquaintances.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
31. I am satisfied with my life.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
33. I feel that something bad is going to happen.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
34. I have sore muscles.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
36. I feel nervous.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
37. I feel my love relationships are full and complete.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
38. I feel that I am not doing well at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
39. I have too many disagreements at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
40. I feel something is wrong with my mind.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
41. I have trouble falling asleep or staying asleep.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
42. I feel blue.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
43. I am satisfied with my relationships with others.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
44. I feel angry enough at work/school to do something I might regret.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
45. I have headaches.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			

Developed by Michael J. Lambert, Ph.D. and Gary M. Burlingame, Ph.D.
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+ +

Total=

Counselor Rating Form – Short (CRF-S)

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

not very X FUNNY very

_____ : _____ : _____ : _____ : _____

not very : : : : : **WELL DRESSED** : **X** : very

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

Though all of the following characteristics are desirable, therapists differ in their strengths. We are interested in knowing how you view these differences.

not very	FRIENDLY	very
not very	EXPERIENCED	very
not very	HONEST	very
not very	LIKABLE	very
not very	EXPERT	very
not very	RELIABLE	very
not very	SOCIABLE	very
not very	PREPARED	very
not very	SINCERE	very
not very	WARM	very
not very	SKILLFUL	very
not very	TRUSTWORTHY	very

Session Evaluation Questionnaire (Form 5)

ID# _____

Date: _____

Please circle the appropriate number to show how you feel about this session.

This session was:

bad	1	2	3	4	5	6	7	good
difficult	1	2	3	4	5	6	7	easy
valuable	1	2	3	4	5	6	7	worthless
shallow	1	2	3	4	5	6	7	deep
relaxed	1	2	3	4	5	6	7	tense
unpleasant	1	2	3	4	5	6	7	pleasant
full	1	2	3	4	5	6	7	empty
weak	1	2	3	4	5	6	7	powerful
special	1	2	3	4	5	6	7	ordinary
rough	1	2	3	4	5	6	7	smooth
comfortable	1	2	3	4	5	6	7	uncomfortable

Right now I feel:

happy	1	2	3	4	5	6	7	sad
angry	1	2	3	4	5	6	7	pleased
moving	1	2	3	4	5	6	7	still
uncertain	1	2	3	4	5	6	7	definite
calm	1	2	3	4	5	6	7	excited
confident	1	2	3	4	5	6	7	afraid
friendly	1	2	3	4	5	6	7	unfriendly
slow	1	2	3	4	5	6	7	fast
energetic	1	2	3	4	5	6	7	peaceful
quiet	1	2	3	4	5	6	7	aroused

IMMEDIATE OUTCOME RATING SCALE

Mark each of the following statements according to how strongly you believe it is true, or not true. Please complete every statement. Write in the corresponding number to stand for the following answers:

- 7 Yes, I strongly believe it is true
- 6 Yes, I believe it is true
- 5 Yes, I believe it is probably true, or more true than untrue
- 4 Neutral, not true or untrue
- 3 No, I believe it is probably untrue, or more untrue than true
- 2 No, I believe it is not true
- 1 No, I strongly believe it is not true

Statements:

- 1. _____ I have only a vague idea of what is wrong in my life.
- 2. _____ I can describe clearly and specifically what needs to be done differently if things are to get better.
- 3. _____ I believe treatment is helping.
- 4. _____ I know what needs to be done in order to solve the problem.
- 5. _____ I am not sure what the problem is.
- 6. _____ Improvement will come quickly.
- 7. _____ I can give clear examples of what the problem is.
- 8. _____ I doubt therapy can do anything to help.
- 9. _____ Therapy will be successful.
- 10. _____ The problem is hard to explain.
- 11. _____ Improvement is already occurring.
- 12. _____ I am not sure what I am doing wrong.
- 13. _____ I do not know what to do to make things better.

14. _____ I can describe how things will be different when therapy is finished.

15. _____ I am not sure what needs to be done to solve the problem.

16. _____ Others will know the problem is solved before I do.

- 7 Yes, I strongly believe it is true
- 6 Yes, I believe it is true
- 5 Yes, I believe it is probably true, or more true than untrue
- 4 Neutral, not true or untrue
- 3 No, I believe it is probably untrue, or more untrue than true
- 2 No, I believe it is not true
- 1 No, I strongly believe it is not true

Appendix G

Evaluation Form for SFBT Intake Interview

Evaluation Form for SFBT Intake Interview

Intake Counselor _____

Date _____

Reviewer _____

Site: Kalamazoo/Grand Rapids/FSU

	Verbatim/Close Variation	Sufficient Follow-up Questions	Clarifying of Question if Needed	Client Understood Question
1. To begin interview	Yes No	Yes No	Yes No	Yes No
Section Comments:				
2. Pre-Treatment Change Question	Yes No	Yes No	Yes No	Yes No
Section Comments:				
3. Complimenting	Yes No	Yes No	Yes No	Yes No
Section Comments:				
4. Miracle Question	Yes No	Yes No	Yes No	Yes No
Section Comments:				
5. Exception Question	Yes No	Yes No	Yes No	Yes No
Section Comments:				
6. Scaling Question	Yes No	Yes No	Yes No	Yes No
Section Comments:				
7. To end interview	Yes No	Yes No	Yes No	Yes No
Section Comments:				

General Comments:

Appendix H
SFBT Training Outline

Solution-Focused Brief Therapy Training

- I. Purpose of this study, introduction and history of SFBT
 - a. Chris Richmond's Dissertation – will examine the differential impact of a Solution-Focused Brief Therapy (SFBT) intake interview vs. Structured Clinical Interview for DSM-IV (SCID-I) intake interview. Each intake worker will receive training in order to deliver both models. The two models will present divergent methods of assessing the client's presenting problems/concerns (the remainder of the SFBT and SCID-I interview will be identical to the standard CCPS intake).
 - b. de Shazer & Berg; Brief Family Therapy Center (SFBT History)
 - c. problem-focused (medical model) assessment vs. solution-focused interview – (pgs. 8-12 *Interviewing for Solutions*).

- II. Solution Building (chp. 2 pgs. 13-19 *Interviewing for Solutions*).
 - a. Case example: interview with Rosie & interviewing activities
 - b. Client's description of the problem
 - c. Developing well-formed goals
 - d. Exploring exceptions
 - e. End of session feedback
 - f. Client as expert

- III. 3 Types of Client-Therapist Relationship (pgs. 58-71 *Interviewing for Solutions*)
 - a. Customer-Type Relationship
 - b. Complainant-Type Relationship
 - c. Visitor-Type Relationship

- IV. SFBT Interventions and Rationale for their use (could go through and use the SFBT Intake Interview as an example and explain the follow-up questions; the interview might flow better if the counselor does not have to read each question or follow-up questions verbatim from the script).
 - a. Miracle Question (pgs. 84-90)
 - b. Compliments (pgs. 34-36)
 - c. Coping Question (pgs. 224-230)
 - d. Exception Question (pgs. 104-106)
 - e. Pre-session Change Question (pgs. 108-109)
 - f. Scaling Questions (pgs. 110-111)
 - g. Identification of Client Strengths and Resources (pg. 107).

V. An Explanation of the SFBT Intake Interview

- a. Read through or give an overview of each component of the interview

VI. Experiential Training

- a. Dr. Bischof leads the first training dyad exercise as the therapist using the SFBT intake interview script/protocol with a participant playing the role of the client (the participant may consult with Dr. Bischof regarding a specific presenting concern/problem). In this dyad exercise Dr. Bischof will administer all components of this interview.
- b. Participants will be asked for questions or comments about the interview.
- c. Participants will be asked to form dyads in which each person will have the opportunity to play the role of therapist and client at least once. The participants will be encouraged to use common concerns/problems as seen in their respective Clinics as issues to present when playing the client role. (In the interest of time participants may not be able to conduct the entire interview as both client and therapist.)

VII. Conclusion & Follow-Up

- a. Participants will be expected to read material from *Interviewing for Solutions* book regarding solution building stages, client-therapist relationships, and the techniques employed in the SFBT intake interview. Participants will also be expected to read and become familiar with the SFBT intake interview script. Each participant will be asked to conduct at least two mock interviews while playing the role of the therapist, and family/friends playing the role of client. The participants will be informed that after completing these requirements they will be given permission to conduct a SFBT intake interview for the purposes of this study, as long as they have also completed the training for the SCID-I intake interview.

VIII. Instructions for the intake worker regarding client recruitment and data collection.

- a. The recruitment process will take place in the waiting room area. Once the client has completed the intake interview paperwork, they can be approached and then read the recruitment script for this study. If the client agrees to participate he/she will then be asked to read the consent document and sign as indicated. NOTE: the intake worker must sign and date this document as well. If the client chooses not to participate, he/she will be administered the standard CCPS intake interview. For those clients choosing to participate, upon signing the consent form they should be asked to deposit that consent form in the drop box at the reception area.

They will be given two copies so that they may have a copy for their records (if choosing to participate). If they choose not to participate they will be instructed to deposit both unsigned consent documents to the drop box.

- b. With the client who has consented to participate, the intake worker should be prepared to deliver either the SFBT or SCID-I intake interview. The intake worker will be given a random assignment list that indicates the order in which they will administer the two intake interviews. The intake workers should be prepared prior to the consent process with either the SFBT or SCID-I intake interview script. Prior to starting the SFBT or SCID-I interview the intake worker should start a videotape recording of this session.
- c. After the SFBT or SCID-I interview has been completed the intake worker should give the participant the survey packet (which includes directions and the 3 outcome measures). Once the instructions are clear, the intake worker should step out of the room while the participant is completing the survey packet, until the participant has deposited the survey into the drop box.
- d. Resume standard intake interview. Following this, the intake worker and participant will reconvene in the therapy room and finish the remainder of the intake interview. The intake worker should be reminded not to repeat any questions that have already been asked either in the SFBT or SCID-I intake interview.
- e. Once you have two intake sessions completed and recorded (1 each of the SFBT & SCID-I), submit the tape(s) to Chris Richmond and he will see to it that a member of the research team will review the taped interviews to ensure that the protocols for both intake interviews are being followed and that appropriate follow-up questions are being asked. Feedback will be provided as needed.
- f. Participants will be asked to consult with Dr. Bischof if they are experiencing any problems administering the SFBT interview, as he will be available for consultation as needed.

Dr. Gary Bischof
(Ofc.) 269/387-5108
(Cell) 269/569-0404
gary.bischof@wmich.edu

Appendix I

Evaluation Form for SCID-I Intake Interview

Evaluation Form for SCID-I (Research Version) Intake Interview
Outline

Intake Counselor: _____ Reviewer: _____

Date of Intake: _____ Review Date: _____

Site: Kal/GR/FSU Total Time: _____ Interview #: _____

1. Overview Question	Yes No NA	Comments:
2. Demographic Data	Yes No NA	
3. Education and Work History	Yes No NA	
4. Overview of Present Illness	Yes No NA	
5. Chief Complaint and Description	Yes No NA	
6. Onset/Exacerbation of Present Illness	Yes No NA	
7. New SXS or Recurrence	Yes No NA	
8. Environmental Context/Precipitants of Present Illness/Exacerbation	Yes No NA	
9. Course of Present Illness or Exacerbation	Yes No NA	
10. Treatment History	Yes No NA	
11. Other Current Problems	Yes No NA	
12. Current Social Functioning	Yes No NA	
13. Most Likely Current Diagnosis	Yes No NA	
14. Diagnosis That Need to be Ruled Out	Yes No NA	
15. SCID Screening Module	Yes No NA	

Evaluation Form for SCID-I (Research Version) Intake Interview
Overall Process

VIII. Interviewing Style

1. Established Rapport	Yes No NA	Comments:
2. Explained Purpose of Interview	Yes No NA	Comments:
3. Handled Subject's Questions Adequately	Yes No NA	Comments:
4. Recognized/Dealt w/ subject's emotional responses during the interview	Yes No NA	Comments:

IX. Obtaining Diagnostic Information

1. Elicited Enough Overview Info to Understand Context/ Development of Problem	Yes No NA	Comments:
2. Elicited Adequate Treatment History	Yes No NA	Comments:
3. Followed Structure of the SCID whenever possible	Yes No NA	Comments:
4. Elicited a description of each symptom in subject's own words	Yes No NA	Comments:
5. Obtained enough information to make judgments on each item	Yes No NA	Comments:
6. Modified questions when necessary to use language that was clear to subject	Yes No NA	Comments:
7. Modified questions when necessary to account for information already obtained	Yes No NA	Comments:
8. Resolved contradictions in subject's story	Yes No NA	Comments:

9. Followed skip instructions correctly	Yes No NA	Comments:
10. Appropriately skipped to sections to consider general medical or substance etiologies	Yes No NA	Comments:
11. Focused interview on time period under consideration (e.g., worst time during episode)	Yes No NA	Comments:
12. Clearly differentiated symptoms that are easily confused	Yes No NA	Comments:
13. Helped rambling subject to focus on the issue under consideration	Yes No NA	Comments:
14. Completed interview in a reasonable period of time	Yes No NA	Comments:

Appendix J
SCID-I Training Outline

Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I) Training

Research Version

Christopher J. Richmond

Eric M. Sauer

I. Purpose of Study

- A. Chris Richmond's Dissertation – will examine the differential impact of a Solution-Focused Brief Therapy (SFBT) intake interview vs. Structured Clinical Interview for DSM-IV-TR (SCID-I) intake interview.
- B. Each intake worker will receive training in order to deliver both models. The two models will present divergent methods of assessing the client's presenting problems/concerns (Note: the remainder of the SFBT and SCID-I interview will be identical to the standard CCPS intake).
- C. The SCID-I is a semi-structured interview, we will only be using the Overview and Screening modules for the purposes of this study.

II. Introduction and History of the SCID-I

- A. The SCID-I is a semi-structured interview used to make DSM-IV diagnoses.
- B. Useful for psychiatric or general medical patients.
- C. Useful for adults with 8th grade reading level.
- D. Individuals with severe cognitive impairment, agitation, or psychotic symptoms cannot be interviewed using the SCID.
- E. Publication of the DSM-III in 1980 revolutionized our field with inclusion of specific criteria sets for virtually all mental disorders.
- F. The first version of the SCID was developed in 1983 in anticipation of the widespread adoption of the DSM-III criteria, and out of a need for a clinical diagnostic assessment procedure. The first version was published in 1996 and several editions have followed.
- G. The SCID-I incorporated several features not present in previous instruments that would facilitate its use in psychiatric research and

assessment, such as the inclusion of the Overview section that allows the client to describe the development of their current episode of illness.

- H. The SCID-I has a Research and Clinical version. For the purposes of this study we will be using the Research version (Overview and Screening modules). The research version of the SCID-I allows the researchers to modify it using only those modules that are relevant to the particular study.
- I. For research, the SCID-I is often used to select a study population or exclude subjects with certain disorders.

III. SCID-I Overview Module and Instructions for Administration

- A. The SCID-I intake interview will begin with the Overview Module.
- B. This module begins with an open-ended overview of the present illness and past episodes of psychopathology.
- C. The Overview provides an opportunity for the subject to describe the presenting problem in his or her own words, as well as collecting certain types of information that may not be covered in the course of assessing specific diagnostic criteria, such as prior treatment and social functioning.
- D. By the end of the Overview the interviewer should have gathered enough information to formulate a tentative diagnosis.
- E. Administration – The introduction of the Overview should be read verbatim to the client “I’m going to be asking you about problems...”
- F. The SCID-I questions should be read verbatim to the client’s except for the parts of questions or complete questions that are in parentheses. Questions in parentheses are to be asked when necessary to clarify responses. For example under the demographic data section the third question reads “Any children? (What are their ages?)” The second question in parentheses would not be routinely asked unless the client reported having children.
- G. Where indicated circle the appropriate response to the question, for example the question “Are you married?” provides 5 options (starting with 1 “married or living with someone as if married” and ending with 5 “never married”).
- H. If possible, before beginning the interview, the intake worker can complete the Demographic Data section of the SCID-I using the information from the CCPS intake paperwork. If this occurs, the intake worker can begin

with the Education and Work History section following the introduction of the Overview.

- I. When asking about a history of past treatment and it becomes clear that the subject has had a particularly complicated history, it may be useful to turn to the Life Chart, located at the end of the Overview. This chart provides the framework for recording past treatment history in a chronological fashion.
 - J. The Overview concludes with the Screening module that contains twelve screening questions.
 - K. With the Screening module, first read verbatim the introduction "Now I want to ask you some more specific questions..." and then ask the twelve subsequent questions without any follow-up or elaboration. You will have the opportunity to ask the client additional follow-up questions later in the intake interview. If a client responds yes to any of the items they should be informed "We'll talk more about that later."
 - L. Screening Module – Not present responses are coded as 1. Unsure or equivocal responses are coded as 2. Presents responses are coded as 3. At the end of the Screening, the appropriate YES/NO boxes corresponding to each screening question should be filled in before proceeding further. In some cases it may be necessary to ask the client to elaborate or provide specific examples in order to rate the corresponding criteria. The intake worker should be encouraged to use their best clinical judgment when the clinical data is not definitive.
 - M. Use one month as the time period for defining "current" for both the Overview and Screening modules.
- IV. SCID Do's and Don't's
- A. Review with intake workers this section of the USER'S GUIDE (pp. 23-26).
- V. Administration Time
- A. Administration of the Overview and Screening modules should take approximately 15 minutes.
- VI. SCID-I Conventions and Usage
- A. Review with intake workers this section of the USER'S GUIDE (pp. 13-15, numbers 1-6). This should be done with a copy of the Overview and Screening module present for reference.

VII. Review of the Overview and Screening MODULES

- A. Have intake workers read through and become familiar with the questions on both modules.

VIII. Experiential Training

- A. Role play cases for practicing how to administer the SCID-I.
- B. Questions or comments about the interview?
- C. Participants will be asked to form dyads in which each person will have the opportunity to play the role of therapist and client at least once. The participants will be encouraged to use common concerns/problems as seen in their respective Clinics as issues to present when playing the client role. (In the interest of time participants may not be able to conduct the entire interview as both client and therapist.)

IX. Conclusion & Follow-Up

- A. Participants will be expected to read *The Structured Clinical Interview for DSM-III-R (SCID)* original article (Arch Gen Psychiatry-Vol 49, 624-629), as well as the sections cited from the USER'S GUIDE FOR THE SCID-I (pgs. 5-15, 23-24, 28-29 "10.2 Overview").
- B. Participants will also be expected to read and become familiar with the SCID-I intake interview script.
- C. Each intake worker need to conduct at least two mock interviews (or homework cases) within one week of this training.
- D. The participants will be informed that after completing these requirements they will be given permission to conduct a SCID-I intake interview for the purposes of this study, as long as they have also completed the training for the SFBT intake interview.

X. Instructions for the intake worker regarding client recruitment and data collection.

- A. The recruitment process will take place in the waiting room area. Once the client has completed the intake interview paperwork, they can be approached and then read the recruitment script for this study. If the client agrees to participate he/she will then be asked to read the consent document and sign as indicated. (NOTE: the intake worker must sign and

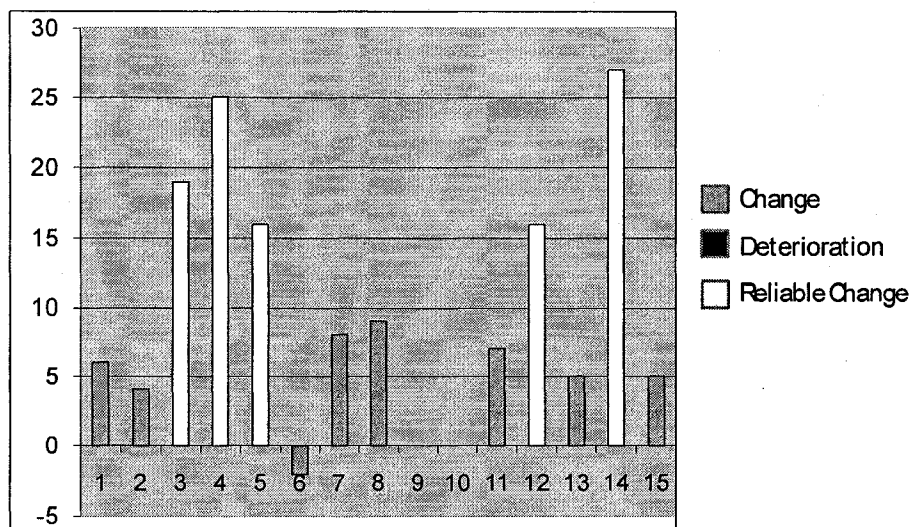
date this document as well. If the client chooses not to participate, he/she will be administered the standard CCPS intake interview.)

- B. For those clients choosing to participate, upon signing the consent form they should be asked to deposit that consent form in the drop box at the reception area. They will be given two copies so that they may have a copy for their records (if choosing to participate). If they choose not to participate they will be instructed to deposit both unsigned consent documents to the drop box.
- C. With the client who has consented to participate, the intake worker should be prepared to deliver either the SFBT or SCID-I intake interview. The intake worker will be given a random assignment list that indicates the order in which they will administer the two intake interviews. The intake workers should be prepared prior to the consent process with either the SFBT or SCID-I intake interview script.
- D. Prior to starting the SFBT or SCID-I interview the intake worker should start a videotape recording of this session. After the SFBT or SCID-I interview has been completed the intake worker should give the participant the survey packet. The intake worker should inform the participant that they should not open the survey packet until the video recording has stopped.
- E. Once the recording has stopped, the intake worker can inform the participant to begin. While the participant is completing the survey packet, the intake worker can remain in the waiting room area until the participant has deposited the survey into the drop box at the reception area.
- F. Following, the intake worker and participant will reconvene in the therapy room and finish the remainder of the intake interview. The intake worker should be reminded not to repeat any questions that have already been asked either in the SFBT or SCID-I intake interview.
- G. Intake workers will be asked to consult with Dr. Sauer if they are experiencing any problems administering the SCID-I interview, as he will be available for consultation as needed. Intake workers will be informed that each interview will be viewed in order to determine that they have followed the script for the SCID-I interview and asked appropriate follow-up questions.

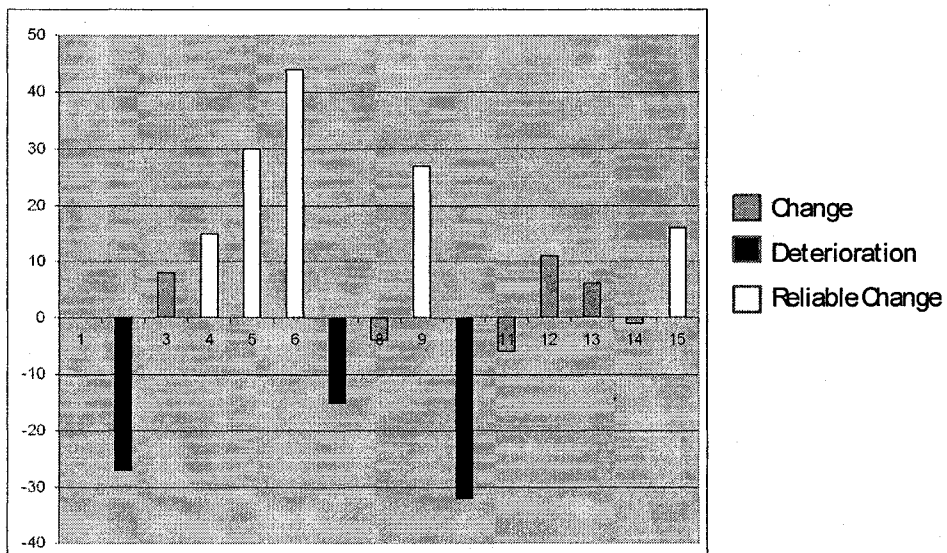
Appendix K

Graphs of SFBT and SCID-I OQ Change Scores

OQ Change Scores: SFBT



OQ Change Scores: SCID



Appendix L

Permission to Use Outcome Measures

From John Corrigan <corrigan.1@osu.edu>
 Sent Friday, April 15, 2005 6:29 pm
 To "Christopher J. Richmond" <chris.richmond@wmich.edu>
 Subject Re: permission to use CRF-S
 Attachments CRF-S.doc

316K

Dear Christopher,

You have our permission to use the CRF-S in your dissertation. You may want to keep a copy of this e-mail, as Dissertation Abstracts sometimes requires documentation of permissions granted in order to include your dissertation.

I have attached a Word version of the CRF-S. Scoring instructions are in the original manuscript (look at the tables to see which adjectives go with each scale). You are free to print, copy and use this version, or cut and paste, as you see fit. There is no fee for your use of the CRF-S, we just ask that proper citation be made.

Good luck with your dissertation.

John Corrigan

>Dear Dr. Corrigan,

>

>I am writing to request permission to use the Counselor Rating Form-
 >Short Version (CRF-S) in my dissertation. I am interested in
 >comparing two versions of an intake interview (diagnostic-focused
 >vs. solution-focused) and the impact of each. Please let me know
 >whether or not you are agreeable to my use of your measure, and if
 >so, how I might obtain a copy. Thanks.

>

>Sincerely,

>

>Christopher J. Richmond, MA
 >Western Michigan University

--

John D. Corrigan, PhD, ABPP
 Professor
 Department of Physical Medicine and Rehabilitation
 The Ohio State University
 480 W. 9th Avenue
 Columbus, OH 43210
 phone: (614) 293-3830
 fax: (614) 293-4870
 e-mail: corrigan.1@osu.edu
 web: www.rehabpsych.org
 www.ohiovalley.org

From Bill Stiles <stileswb@muohio.edu>
 Sent Friday, April 15, 2005 11:57 am
 To "Christopher J. Richmond" <chris.richmond@wmich.edu>
 Subject Re: request to use SEQ
 Christopher,

Yes, you are welcome to use the SEQ in your research. There is a brief description and a downloadable copy posted on my web site at:

http://www.users.muohio.edu/stileswb/session_evaluation_questionnaire.htm

I'd be very interested in seeing a copy of the results of your research, when it's ready.

Best wishes,
 Bill

At 10:37 AM 4/15/05, you wrote:

>Dear Dr. Stiles,
 >
 >I am writing to request permission to use the Session Evaluation
 >Questionnaire in my dissertation. I am interested in comparing two
 >versions of an intake Interview (diagnostic-focused vs. solution-
 >focused) and the impact of each. Please let me know whether or not
 >you are agreeable to my use of your measure, and if so, how I might
 >obtain a copy. Thanks.
 >
 >Sincerely,
 >
 >Christopher J. Richmond, MA
 >Western Michigan University

 William B. Stiles
 Department of Psychology
 Miami University
 Oxford, OH 45056
 USA
 Voice: +1-513-529-2405
 Fax: +1-513-529-2420
 Email: stileswb@muohio.edu
<http://www.users.muohio.edu/stileswb/>

From Jerome Adams <jadams@mail.uri.edu>
Sent Tuesday, November 1, 2005 4:21 pm
To chris.richmond@wmich.edu
Subject RE: quick question
Hi Chris,

You are more than welcome to use the instrument. Sounds like an interesting project.

Jerome

-----Original Message-----

From: chris.richmond@wmich.edu [chris.richmond@wmich.edu]
Sent: Monday, October 31, 2005 10:07 PM
To: jadams@uri.edu
Subject: quick question

Hi Dr. Adams,

My name is Chris Richmond, I am a PhD Counseling Psychology student at Western Michigan Univeristy studying under Dr. Alan Hovestadt. My dissertation will look to compare the differences between a SFBT intake interview versus a problem/diagnositic-focused intake interview. As one of my outcome measures I would like to use the Immediate Outcome Rating Scale (IORS) which you used in your dissertation and also cited in a 1991 article. Would you be willing to grant me permission to use this instrument in my dissetation?

Thank You,

Chris Richmond

Chris

You can use this sample copy.
Thank you,

Tameisha Hastings
OQ Measures
2150 South 1300 East Suite 529
Salt Lake City, Utah 84106
Phone: (888) MHSCORE (647-2673)
Fax: (801) 990-4236

-----Original Message-----

From: Chris James Richmond [mailto:chris.richmond@wmich.edu]
Sent: Thursday, October 25, 2007 5:41 PM
To: office@oqmeasures.com
Subject: permission to reprint OQ

To Whom it May Concern:

My name is Chris Richmond, I am a doctoral candidate at Western Michigan University. I am completing my dissertation, which included the OQ-45 as an outcome measure. The two sites I collected data at had purchased the OQ prior to the start of my data collection, and thus had authorization to use this instrument. I am wondering if you could tell me how I would go about obtaining permission to reprint the OQ-45 as an appendix in my dissertation.

Thank You,
Chris Richmond

College of Physicians & Surgeons of Columbia University | *New York, N.Y. 10032*

Michael B. First, M.D.
Professor of Clinical Psychiatry
Research Psychiatry II
New York State Psychiatric Institute

1051 Riverside Drive
Unit 60
Tel: (212) 543-5524
Fax: (212) 543-5525
E-mail: mbf2@columbia.edu

October 11, 2005

Mr. Chris Richmond
Western Michigan University
C/O 4700 West 27th Street
Apartment II-5
Lawrence, KS 66047

Phone: (785) 864-2277

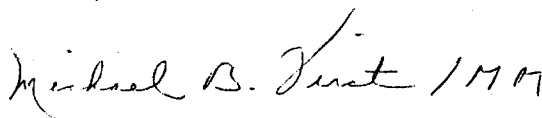
Dear Mr. Richmond:

Enclosed is a copy of the Structured Clinical Interview (SCID-1) Research Version for DSM-IV-TR Axis I Disorders, November 2002 Edition, with January 2004 Page Updates and User Guide, for your use in your dissertation research study.

You may make as many copies as needed for your dissertation and may also include a copy in the appendix of your dissertation.

Wishing you all the best in your research endeavors.

Sincerely,

Handwritten signature of Michael B. First in cursive script.

Michael B. First, M.D.
Professor of Clinical Psychiatry
Columbia University
Research Psychiatrist II
NYS Psychiatric Institute

Cc: Miriam Gibbon, M.S.W., Research Scientist – E-mail: mg22@columbia.edu
Maureen McCabe, Secretary – E-mail: mccabem@pi.cpmc.columbia.edu

Appendix M

WMU Human Subjects Institutional Review Board Approval

WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: December 13, 2005

To: Alan Hovestadt, Principal Investigator
Gary Bischof, Co-Principal Investigator
Eric Sauer, Co-Principal Investigator
Christopher Richmond, Student Investigator for dissertation

From: Mary Lagerwey, Ph.D., Chair

A handwritten signature in cursive script, reading "Mary Lagerwey".

Re: HSIRB Project Number: 05-10-37

This letter will serve as confirmation that your research project entitled "A Study of Intake and Assessment in Solution-Focused Brief Therapy" has been **approved** under the **full** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: November 16, 2006

Walwood Hall, Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276

Appendix N

FSU Human Subjects Research Committee Approval



Connie Meinholdt, Ph.D.
Psychology Program
820 Campus Drive
Ferris State University
Big Rapids, MI 49307
(231) 591-2759

To: Dr. Christopher Richmond
From: C. Meinholdt, HSRC Chair *CM*
Re: HSRC Application #061007 (Title: A study of intake and assessment in solution-focused brief therapy)
Date: November 13th, 2006

The Ferris State University Human Subjects Research Committee (HSRC) has reviewed your project, "" and approved your research under the category of expedited (2G)

Your application has been assigned a project number (#061007) which you may wish to refer to in future applications involving the same research procedure. Also, project approvals receive an expiration date one year from the date of approval. As such, you may collect data according to procedures in your application until November 14th, 2007.

Best wishes for a successful research endeavor and please let me know if I can be of future assistance.