12-1-2003

The Relationship Between Personality and the Experience of Solution-Focused Therapy and Cognitive Therapy

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THE RELATIONSHIP BETWEEN PERSONALITY AND THE EXPERIENCE OF SOLUTION-FOCUSED THERAPY AND COGNITIVE THERAPY

by

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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota
December
2003

This dissertation, submitted by Shannon T. Woulfe, in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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August 29, 2003
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Department Psychology

Degree Doctor of Philosophy

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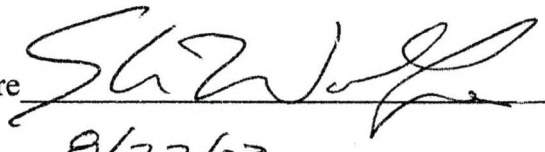
Signature 

Date 8/27/03

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ACKNOWLEDGEMENTS

I would like to express appreciation to all of the individuals involved in the completion of this study. I would like to specifically acknowledge the guidance provided by my advisor, Dr. James Antes. His input and support were invaluable in the completion of this project. I would also like to thank each of the members of my dissertation committee, Dr. Alan King, Dr. Cheryl Terrance, Dr. John Tyler, and Dr. Janet Moen, for their valued contributions to this project.

I would like to thank the individuals that helped to create the therapy videos used in this study. I appreciate the comments and critiques offered by Dr. Kit O'Neill, Dr. Kim LaHaise, Dr. Insoo Kim Berg, and Dr. Peter DeJong. I am also thankful for the efforts put forth by the actors, Dawn Kidle and Kelly S. Clow. I appreciate the University of North Dakota Family Practice Center for offering their facilities as the setting for the videos. Finally, I am grateful for the time and effort offered by Dr. Mark Grabe to teach the appropriate methods for capturing and editing video files.

I would like to recognize the work done by the research assistants on this project, Seth Christman and Kimberly Majkrzak. Their responsible and professional work was greatly appreciated.

Finally, I would like to thank my family and friends who supported me throughout the completion of this project. I want to thank my Father for his unwavering

support of my education and success, especially during this past year. Thanks to my Mother, who in her darkest hour continued to focus on my education. I truly appreciate everything you did to make this possible.

For my Mother and Father

ABSTRACT

Throughout the past 20 years, a growing emphasis on client competence building within the psychotherapy literature has led to the creation of specific therapeutic interventions, such as narrative therapy and solution-focused therapy. These interventions offer a distinct alternative to traditional deficit-based interventions, where clients are viewed as having a dysfunction that is causing specific symptoms. This study indirectly compared the experiences of a client undergoing a competence model of helping, solution-focused therapy, with the experiences of the same client undergoing a deficit model of helping, cognitive therapy. Information about how personality dimensions are related to the experience of both solution-focused and cognitive therapies was also examined.

The sample used in this study was comprised of 117 undergraduate students. They were presented with a videotaped simulated therapy vignette of either solution-focused therapy or cognitive therapy. They were asked to imagine themselves as the client within the vignette. Following this presentation, participants were asked to complete a series of questionnaires that inquired about techniques observed, expected outcomes, and perceived experience. Participants were then presented with the other therapy vignette and asked to complete the same measures regarding it. Finally,

participants were asked to complete a third series of questionnaires that assessed therapy preference and demographic information. At that time, participants also completed the MCMI-II as a measure of personality.

The results of this study failed to identify strong associations between personality dimensions and preference of therapy. Such an outcome suggests that other factors are more associated with preference for therapy than personality. Cognitive therapy was found to be rated as more effective and more preferred than solution-focused therapy. Such results are consistent with the prevalence of deficit-based interventions. The extensive exposure of deficit-based interventions in various media presentations may have created expectations about therapy that are influencing the results found here. Additional analyses were conducted to examine the perceived experience of both forms of therapy. Cognitive therapy was overwhelmingly rated as more positive - affectively, cognitively, and behaviorally - than solution-focused therapy. These results also were interpreted as resulting from the prevalence of deficit-based interventions.

CHAPTER I

INTRODUCTION

The field of psychology is comprised of many diverse theories, concepts, and applications. This diversity is illustrated in the theories and concepts underlying psychotherapy. There are many forms of psychotherapy, such as psychodynamic therapy, cognitive therapy, and behavioral therapy, each based upon different theoretical foundations and espousing different treatment methods. Nevertheless, this presence of therapeutic diversity is not without an underlying commonality. The majority of therapeutic interventions utilize a "deficit" model of understanding an individual and his/her problems (Greene, Lee, Trask, and Rheinscheld, 1996). Within this framework, clients are viewed as having a dysfunction that is causing specific symptoms. The therapist is characterized as an authority who is able to identify and correct such a dysfunction in order to reduce symptoms. Although psychodynamic, cognitive, and behavioral therapies differ on their origins and methods of treatment, they have in common this deficit approach.

In stark contrast to the deficit model, there is an emerging movement which has a focus on the client's positive qualities. Such a perspective removes the emphasis on pathology and replaces it with an emphasis on strength and competence. This movement can be observed, in its earliest incarnation, through the work that has been categorized as third force psychology. In the 1960's, third force psychology developed as a response to the two dominant theories of psychology at the time, psychoanalysis and behaviorism. Psychological theorists of this time, including individuals such as Carl Rogers and Abraham Maslow, felt that psychology placed too much importance on negative,

pathological client characteristics. In response, they developed theories and interventions that placed significance on positive client characteristics. Many of the ideas developed by third force psychologists are still utilized today in one form or another. Along with the continued use of the ideas from these individuals, in the past several years there has been a modern renaissance in psychology emphasizing positive qualities. This is illustrated by two current issues of *American Psychologist* (January 2000 and March 2001) being completely devoted to "positive psychology," a relatively new movement emphasizing individuals' positive qualities. These issues extend the work of third force psychology through the exploration of concepts such as optimism, creativity, and resilience.

The development of solution-focused therapy is an additional manifestation of a similar, modern, emphasis on individuals' positive qualities. This form of therapy, originally described in the 1980's (Lamarre and Gregoire, 1999), attempts to utilize client resources, competencies, and past successes to facilitate change in a current problem.

In the sections that follow, information is conveyed about a growing emphasis on positive qualities which can be observed through solution-focused therapy and other related concepts. Included in this information is a theoretical discussion about the evolution of therapy not consistent with the currently dominant "deficit" model. Further information about earlier positive movements in psychology is also offered. As the role of client competence is explored, it becomes evident that there is an increasing emphasis placed on the role of language in therapy. Thus the ramifications of such a language emphasis are delineated. Furthermore, the research on client competence is somewhat limited, however there are additional related concepts that may provide further understanding beyond this sparse literature. Critical examination of these individual concepts provides information supporting their conceptual commonalities with client competence. An examination of each of these individual concepts will produce a more complete understanding of client competence. Additionally, detailed descriptions of

narrative therapy and solution-focused therapy are offered as examples of how client competence may be effectively utilized in psychotherapy. The goal of the study presented here is to examine how the experience of deficit-based therapy differs from the experience of competence-based therapy. Since past research has found that personality factors are related to the experience of deficit-based therapy, exploration of how personality factors interact with the experience of therapy, both deficit-based and competence-based, is a logical and relevant issue to be investigated. Thus, specific details about the impact of various personality dimensions on multiple aspects of the therapeutic process are described. Through an understanding of both past research examining client competence and the research exploring the relationship between personality and the therapeutic experience, the context for the study presented here can be understood.

Theoretical Explanations of Therapy

In order to better understand how deficit-based interventions are different from competence-based interventions, it is crucial to examine their theoretical origins in structuralist and post-structuralist thought. Structuralism proposes the idea that there is an all-encompassing system that incorporates multiple interconnected facets (de Shazer, 1991). This idea translates to therapy through the definition and remediation of psychological problems. Under a structuralist idea, all psychological problems are able to be categorized into specific definitions. For example, depression may be structurally defined as having feelings of hopelessness. Additionally, the methods for reducing such problems are equally prescribed. For example, in order to help an individual with depression, one must target how the problem initially occurred. Thus irrational cognitions, faulty learning, or failed development may be targeted for treatment. Contrary to structuralism, post-structuralist thought rejects the structuralist ideals of a

complete system and interconnected facets. Post-structuralist ideas are more consistent with an emphasis on individual experience (de Shazer, 1991). This can also be translated to the therapy setting. A post-structuralist psychologist places more importance on how the client describes his/her situation as a method of constructing a subjective reality. For example, a client may not endorse symptoms consistent with the structuralist view of depression, but he/she may report feeling "depressed." In this case it is crucial to understand what factors the client is focused on that has led him/her to the conclusion that he/she is depressed. Clearly structuralism and post-structuralism convey very different forms of thought that have progressed to influence the development of different forms of therapy.

Although there have been various forms of unique psychological interventions developed, the vast majority of them arise from structuralist thought. From a structuralist perspective, individuals are secondary to their context. Individuals are fit into a world made of a stable framework. The framework dictates the explanation of an individual experience. For example, an individual is explained as depressed if they fit the description of having feelings of hopelessness. Such a framework is generated through the collective understanding of multiple concepts. Thus, each word, term, or concept has an ultimate definition that is dictated by this framework. De Shazer (1991) suggested that there are two specific components that are used to create such definitions. These components are the signifier and the deep structure. The signifier is the outward representation of the term whereas the deep structure is comprised of the complex understanding of the term. It is suggested that structuralism has such a mass appeal because it, by definition, explains everything with absolute certainty (de Shazer, 1994). The use of structuralism eliminates inconsistencies or alterations of conceptual meanings. Traditional psychological interventions adhered to this structuralist thought through their

conceptualizations of problem origins. According to structuralism, the assumption is that if there was the presence of a problem, there must be an identifiable causation as its source (de Shazer, 1991). For example, an individual may experience depressive symptoms in reaction to specific irrational thoughts.

A key characteristic of the structuralist view of psychological interventions is that objectivistic viewpoints are utilized for problem identification and symptom reduction. The objectivistic viewpoint is characterized by an examination of structure as causative elements maintaining the specific problems. An illustration of the objectivistic perspective may be a situation where negative interpersonal relationships are the causative elements maintaining the specific problem of depressive symptoms.

The application of objectivistic and structuralist interpretations may not be beneficial and may actually be harmful for individuals seeking psychological assistance. Riikonen (1993) described three problems with the objectivistic point of view. The first problem is that objectivistic thinking promotes the use of negative self-narratives. Thus the client continues to use negativistic thinking about his/her current problem situation. The second problem suggests that objectivistic problem classification tends to strengthen the permanence and pervasiveness of the problem. By focusing on the problem and its origin, the intervention may be harmful rather than helpful. Finally, the last defect of objectivistic thinking identified by Riikonen (1993) is that this type of thinking does not produce information that helps the client. This type of thinking completely neglects the influential resources of the client and his/her surrounding support system (Riikonen, 1993). Through the identification of such pervasive and inherent problems, Riikonen (1993) advocated the use of "post-structuralist thought," rather than objectivistic thought, to govern psychological interventions.

Contrary to structuralism, a post-structuralist view offers a very different

perspective on the psychological helping process. Like Riikonen (1993), de Shazer (1991) suggested that the most useful way to understand a client's world is through post-structuralist thought. These authors use of the term post-structuralism is very similar to others' conceptualization of post-modernism. Unlike structuralism, post-structuralistic thought denies the existence of general laws of language that define a client's world and social context (de Shazer, 1991). Post-structuralist thought suggests that meanings are unique constructions of the specific term and the person using the term. Therefore, post-structuralist meanings are by definition arbitrary and unstable (de Shazer, 1994). Post-structuralist thought purports that a client's world is established through language. In order to understand a client's situation, particular attention must be given to his/her words and how the words are used. Through verbal descriptions, individuals create a subjective reality where their use of language and their world become the same entity. An additional theoretical conceptualization that is congruent with the characteristics of post-structuralist thought is constructivism. Constructivism is best described by the statement "reality is invented rather than discovered" (de Shazer, 1991, p. 44). This statement is consistent with the post-structuralist idea that language creates reality. Because of this idea, Riikonen and Smith (1997) suggested that words have an enormous potential within constructivist thinking. Constructivist and post-structuralist theories offer a perspective substantially different from the traditional structuralist approach. The structuralist perception of identifying how the client and his/her problem fit into the present world structure is no longer appropriate because, from a post-structuralist perspective, it does not make sense to separate the world from one's experience of it. The primary focus is instead placed on the desire to understand how the client develops his/her own world and how the "problem" exists within this world.

Deficit Perspective

As could be inferred from the discussion of structuralist and post-structuralist thought, psychology has developed numerous forms and styles of interventions. Each of these interventions has been based explicitly or implicitly on theories of personality and pathology. Some of the most prominent forms of psychological intervention include psychoanalysis, behavior therapy, and the currently dominant cognitive-behavioral therapy. Each of these forms of interventions utilize different tools to alleviate psychological distress. Despite their differences, each of these models of psychological intervention are based on a "deficit perspective" (Greene et al., 1996, p. 61). Each of these psychological interventions views the client as having a specific deficiency that is causing the current psychological problem. A psychoanalytic interpretation of psychological distress may focus on incomplete development as the deficiency causing the problem. According to a behavioral interpretation, psychological distress may be caused by learning ineffective and harmful responses to environmental stimuli. Inherent in this logic is the idea that each psychological intervention has the ability to "fix" this deficit and reduce or remove the psychological problems. The idea that the presence of a deficiency is causing psychological problems and the inferred ability to "fix" the problem is best seen through multiple interpretations of a cognitive approach. It is not uncommon for cognitive psychologists to identify problems through "irrational thoughts," (McMullin, 2000, p. 88) "dysfunctional thinking," (Beck, 1995, p.1) or "unrealistic beliefs," (Ellis, 1995, p.164). Additionally, these same deficit oriented psychologists tend to "fix" such problems through an "attitude change," (McMullin, 2000, p. 88) "modification of thinking," (Beck, 1995, p.1) or an attempt to "examine and change some of their [the client's] basic values," (Ellis, 1995, p.164). Each of these interventions

highlight a specific deficiency causing psychological problems. Clearly the deficit perspective is the currently dominant way of conceptualizing psychological interventions.

Positive Movements

Even though psychological theory has often focused on psychological problems and disorders, there have been movements that have attempted to place a focus on more positive concepts. The first, and most dominant, movement to do so was third-force, or humanistic psychology, which can trace its intellectual ancestry to 18th century romantic philosophy and 19th century existential philosophy. In the 1960's, many psychologists felt that the two major schools of psychology, psychoanalysis and behaviorism, were incomplete. Specifically, it was thought that there needed to be a "model of humans that emphasized their uniqueness and their positive aspects rather than their negative aspects" (Hergenhahn, 2001, p. 505). Third-force psychologists rejected ideas of determinism and embraced concepts of free will and subjective reality. One of the best illustrations of third-force psychology can be observed through the work of Carl Rogers. Rogers developed a client-centered approach to therapy, which focuses on the client's present situation rather than his/her past. Additionally, Rogers believed that in the right context, each individual could solve his/her own problems (Hunt, 1993). This philosophy is evident in a dialogue Rogers conducted with Martin Buber where he stated:

> "As I see...people coming together *in* relationship in therapy, I think that one of the things I have come to believe and feel and experience is that...what I think of as [sic] as human nature or basic human nature...is something that is really to be trusted....it's been very much my experience in therapy that one does not need to supply motivation toward...the positive or toward the constructive. That exists in the individual" (Anderson and Cissna, 1997, p.77-78).

Clearly, the work of Carl Rogers and other third-force psychologists utilized a focus on the positive qualities of human beings. Third-force psychology became very popular during the 1960's and 1970's; nevertheless the 1980's saw a substantial decrease in its popularity.

Despite the waning interest in third-force psychology, a very recent movement has resurrected many similar ideas and concepts. This new branch of psychology is identified as positive psychology. Positive psychology is "the scientific study of ordinary strengths and virtues" and "an attempt to urge psychologists to adopt a more open and appreciative perspective regarding human potentials, motives, and capacities" (Sheldon and King, 2001, p. 216). The roots of positive psychology are embedded in third-force psychology. Resnick, Warmoth, and Serlin (2001) indicated that the term "positive psychology" originated in the work of Maslow from 1954 (p. 74). Currently, positive psychology attempts to bridge the gap between humanistic, third-force psychology and modern psychology. The main focus of positive psychology encompasses investigation into such topics as optimism, happiness, and resilience. In addition, the positive psychology movement has implications for psychotherapy. Whereas traditional, deficit approaches attempt to correct a specific problem, the therapist practicing positive psychology attempts to help the individual grow, through the utilization of personal resources, in addition to assisting in specific problem solving. At this time, positive psychology does not describe particular methods for treatment, however it does suggest a certain focus. Seligman and Csikszentmihalyi (2000) claimed that "Treatment is not just fixing what is broken; it is nurturing what is best" (p. 7). These ideas expressing the tenets of positive psychology are highly consistent with certain modern forms of therapy such as narrative therapy and solution-focused therapy.

Importance of Language

One of the main differences between deficit perspectives and approaches emphasizing positive client characteristics is the use of language. The manner in which language is used is a crucial factor in the development of competence-focused psychological interventions. Competence-based interventions intentionally place more focus on language than deficit-based interventions. In accordance with constructivist thinking, language in competence-based therapy is used as the primary method of understanding a client's world. This functions to place more emphasis on the client and the telling of his/her story. Therefore, this added focus on language removes most perceptions about a hierarchy of power from the therapeutic relationship. The authority of the therapist is replaced with an increased level of authority for the client. The responsibility of change is placed on the client. Through this shift of responsibility, clients are able to recognize and utilize their personal resources to facilitate symptom reduction and overall improvement. Thus, an increased focus on language results in a greater understanding of the client's world, which promotes the development of a greater sense of empowerment for the client.

Researchers have attempted to describe how language is used in therapy. Miller and de Shazer (2000) dissected the use of language in the therapeutic setting to better understand its use. These authors used concepts from Wittgenstein (1953, as cited by Hergenhahn, 2001) to identify how constructivism can be applied to therapy. One of these concepts is "language games" which is identified as the organized ways we use language. Examples of language games include personal demeanor, appearance, and social settings. Miller and de Shazer (2000) suggested that language games are used to construct specific ways of living life identified as "forms of life" (p. 8). These two concepts interact reflexively to socially construct the world of the client. In this manner,

constructivist, post-structuralist ideas are applied to current conceptualizations of therapy in order to create reality. Thus, the constructivist, post-structuralist ideas can be easily observed in the growing emphasis on competence.

The amount of emphasis placed on client competence can have a tremendous impact on the manner in which language is used in therapy. According to traditional psychotherapies, the psychologist is seen as the expert who is attempting to implement interventions to remedy a specific deficit in the client. However, post-structuralist ideas remove the authority of the psychologist. By adopting the post-structuralist ideas, the language used by the client is seen as the ultimate description of the client's situation. In order for any communication to take place, a basic assumptions must be present for the meanings of various aspects of language; however, according to post-structuralist thought, these assumptions should not extend to details about the client and his/her problem situation. Boldt and Mosak (1998) indicated that "the client, not the therapist, is both the expert on the life story and the author of change" (p. 507). Therefore, as the client is the authority on the problem and the primary agent of change, a focus on the client's competence helps facilitate change. Beyond the concept of the client as the expert, the private experience of emotions also signifies the connection between the client competence and language. Emotions are experienced internally, often with little or inconsistent external reactions. Therefore, the only way to accurately assess emotions is through the words of the client. This suggests that the practical meanings of words should be dictated by the clients (Miller and de Shazer, 2000; de Shazer, 1991). For example, what does a client mean when he/she says they feel "better" or "depressed?" Such non-specific concepts highlight the importance of using the client's definition of the terminology in order to accurately understand the situation. In order to obtain the client's definition, de Shazer (1991) suggests that the client describe the criteria or evidence that

they have used in their own life to determine the use of such terminology. In this manner, the therapist learns exactly how the client is using specific vocabulary. Such a method also facilitates the understanding of how the individual experiences of the client fit into previously identified categories for purposes of diagnosis and professional communication. Overall, the emphasis on client competence and the constructivist approach may have a substantial impact on the use and value of language in therapy.

Conceptualizing Competence

The psychological literature specifically focused on client competence is very limited. However, this is likely due to imprecise conceptual labeling. In actuality, a growing emphasis can be observed by going beyond the client competence literature and examining the multiple concepts that have been utilized to identify and describe client competency. Personal agency (St. James, 1997) and "strengths" perspectives (Greene et al. 1996) are just two unique terms that attempt to describe aspects of client competence. This substantial variability in conceptual labels masks the similarities between concepts and the collective contributions of theories and research examining competence. Specific examinations of some of the competence-related concepts may function to solidify the understanding of the current state of competency as used in psychology.

A concept that describes one aspect of competence is "mindfulness" as explained by Norum (2000). This author indicated that he first began exploring the concept of mindfulness because "People were somehow coming up with their own healthy solutions" (Norum, 2000, p.19). The author used the concept of mindfulness to identify a helping perspective that reduces a focus on pathology and increases a focus on solutions. Such solutions are reached through various forms of introspection. "Mindfulness teaches awareness of the physical 'self' by focusing on bodily sensations and breathing...[which] slows down the thought process, allowing one to more easily decide which thoughts are

useful and which thoughts are useless..." (Norum, 2000, p.18). In this manner, the mindfulness approach incorporates a philosophy consistent with concepts from Eastern thoughts and even meditation. Nevertheless, inherent in the description of mindfulness is the idea that individuals have the capacity to work through problems on their own. Such conceptualization is highly consistent with the growing emphasis on client competence.

O'Conner, Meakes, Pickering, and Schuman (1997) identified another competence-related concept within their discussion of therapeutic experience, personal agency. These authors indicated that personal agency is developed through identification of the connection between personal problem-solving abilities and personal attributes (O'Conner et al. 1997). Questions from the therapist are used to allow the client to connect his/her own personal characteristics with his/her ability to resolve difficult issues. In this manner, personal agency is classified as a concept that emphasizes client competence. These authors concluded that the development of personal agency was the most noticeable factor in family therapy. They also determined that "Somehow, families feel empowered by therapy as they come to recognize that they are able to make some changes in the problem" (O'Conner et al., 1997, p.491).

Much of the current understanding of client competence has developed from the work of M.H. Erickson. "The use of client's competencies in therapy is as central to Erickson's work as interpretation is to Freud's" (Lamarre and Gregory, 1999, p.46). This centrality is most evident in the "utilizational approach," a concept characterized by an emphasis on client abilities throughout therapy (Lamarre and Gregory 1999). "Erickson viewed clients as having within them...the resources to make the changes they need to make" (O'Hanlon and Weiner-Davis, 1989, p.16). In this manner, therapy is viewed as a process where the therapist uses specific techniques in order for the client to employ the personal abilities which already existed within them to resolve problems. Even though

Erickson's "utilizational approach" was just one component of his nontraditional treatment, it provides a strong foundation for the current emphasis on client competence. Specifically, this conceptualization of client competence provided the initial ideas from which de Shazer developed solution-focused therapy (de Shazer 1989).

Perhaps one of the clearest illustrations of the growing emphasis on client competence can be observed through the "competence transfer" work of Lamarre and Gregoire (1999). These authors used Erickson's utilization approach as a starting point to create a modified version of therapy that includes a primary focus on client competencies. In this form of therapy, the therapist acts as a guide to help the client uncover his/her own abilities that can be employed to resolve problems. Specifically, the therapist attempts to identify specific competencies and then establish a connection between such competencies and current difficulties. Lamarre and Gregoire (1999) suggested that "Once clients discover they possess the ability to solve the problem, there follows a perception that whatever the problem in the future, the solution is within them" (p.55-56) The creation and implementation of this method of intervention highlights the importance of client competence as a factor to be examined in the therapeutic setting.

The growing emphasis on client competence is not only found in theoretical conceptualizations, but this emphasis is also found in therapy. As previously discussed, Lamarre and Gregoire (1999) utilized an emphasis on client competence to create a specific protocol to be used in the therapeutic setting. Others have developed specific forms of therapy that employ a primary focus on client competencies. Two of the most prominent such therapies include narrative therapy and solution-focused therapy. Riikonen (1993) suggested that there are three factors that make these therapies effective. First, both therapies facilitate ways of thinking that emphasize competence. In slightly different manners, both narrative therapy and solution-focused therapy promote thoughts

about past successes and skills that might be helpful for future situations. The second factor described by Riikonen (1993) is that both forms of therapy attempt to dissect language in order to deconstruct obstacles that prevent a focus on competencies. This focus on language is consistent with ideas expressed by Miller and de Shazer (2000) and Boldt and Mosak (1998) in that language is used in both instances to dictate the course of therapy and promote personal improvement. Finally, the third factor identified by Riikonen (1993) that facilitates the effectiveness of both narrative therapy and solution-focused therapy concerns the creation of small individual evaluations. Each of these therapies incorporates situations where the client is able to "test" his/her coping ability within the parameters of a specific subjective obstacle. Thus through an emphasis on competence, focus on language, and implementation of personal evaluations each of these therapies are identified as "ways of seeing problems and goals which both activate the client and dismantle harmful problem definitions" (Riikonen 1993, p.148). However, even with the presence of similar underlying theory, narrative therapy and solution-focused therapy have unique characteristics that make them distinct forms of psychological intervention.

Narrative Therapy

One of the currently prominent forms of therapy that utilizes a focus on client competence is narrative therapy. Like other modern forms of therapy, narrative therapy involves a social constructivist approach toward therapeutic change. "Change occurs by exploring how language is used to construct and maintain problems" (Etchison and Kleist, 2000, p.61). Michael White, a prominent psychologist involved in the creation of narrative therapy, along with his coauthor David Epston (1990), delineated many of the theoretical foundations of this form of intervention. White and Epston concurred that power is constructed within language. They suggested that an amalgam of events that

occur in the past, present, and future are used in order to provide information about the client, which is labeled a "self-narrative" (White and Epston 1990, p.10). This self-narrative is in essence a story of the client's life. The overarching goal of narrative therapy is for the therapist and the client to "co-author" a new and improved story, free from the obstacles present in the initial self-narrative (White and Epston 1990, p.17). Even though both the therapist and the client are involved in creating a new story, narrative therapy maintains a competence focus by placing the responsibility for change on the client rather than the therapist. "...The therapist can only suggest possible interpretations and help the client explore alternative ways of thinking and behaving. The actual change is the client's responsibility" (Boldt and Mosak 1998, p.507). Clearly, examination of the theoretical foundations of narrative therapy reveals a strong emphasis on client competence.

The general techniques involved in narrative therapy, as well as its theoretical premises, also reveal a substantial focus on client competence. As the content of therapy is coconstructed by both the therapist and the client, the content of the therapy is understandably fluid and variable. Nevertheless, there are four components common to narrative interventions (St. James O'Connor et al., 1997). The first component concerns the externalization of the problem. "[Clients] may view themselves as the problem and create stories of themselves that depict a lack of power and worth. Problems may not be seen by them as external events that affect and influence their lives and, thus are maintained" (Etchison and Kleist 2000, p.61). Thus, the initial focus of narrative therapy involves the separation and externalization of the problem from the client. The second component of narrative therapy concerns the creation of an alternate story. Alternative stories unlock previously neglected aspects of experience, particularly aspects that focus on exceptions to problem-related situations. In this manner, the client is able to see that

the presence of specific factors does not automatically produce the associated negative consequences. The third component of narrative therapy involves the development of personal agency. Narrative therapists employ questions that allow their clients to recognize their own resources. In many such situations, information about personal qualities of the client can be used to obtain information about problem solving ability (St. James O'Connor et al., 1997). Finally, the last component of narrative therapy concerns increasing the audience for change. Clients are asked to hypothesize what other individuals around them may notice in the absence of the client's problem. This line of inquiry serves multiple functions as it allows the client to estimate the perceptions of other individuals and it also forces the client to compare his/her current problem situation with their perception of the problem's absence. Clearly the four components of the narrative therapy technique embody characteristics consistent with an emphasis on client competence.

Solution-Focused Therapy

Solution-focused therapy is another modern form of therapeutic intervention that is grounded in client competence. Even though solution-focused therapy was developed before narrative therapy (Lamarre and Gregoire, 1999), in many ways solution-focused therapy has a much stronger emphasis on client competence. This emphasis can be observed through examination of the theoretical origins of solution-focused therapy, the manner in which therapy is implemented, and some of the specific techniques that are unique to solution-focused therapy.

Solution-focused therapy began taking shape during the early 1980's. Borrowing from previous theorists such as M. H. Erickson, de Shazer began defining concepts and practices that would later be identified as solution-focused therapy (de Shazer, 1985; 1986; and 1988). Solution-focused therapy evolved out of inductive reasoning from

numerous hours of observing the therapeutic process (Berg and DeJong, 1996). With an understanding that each individual and each situation are unique, de Shazer and his colleagues concluded that there is more than one potential solution for each problem. Through an emphasis on personal empowerment and an amplification of success, it was theorized that each individual would be able to use his/her own personal resources to solve his/her own problems (DeJong and Berg, 2002; O'Hanlon and Weiner-Davis, 1989). Specifically, de Shazer (1985) theorized that there are a set of general techniques, or skeleton keys, that may be used for various individuals and problems that assist the client in problem solving.

Even though de Shazer has written many volumes about solution-focused literature, perhaps the most complete work for the training of solution-focused therapy was written by De Jong and Berg (2002). In this text, they offered detailed guidance for every step of solution-focused therapy along with explanation through specific case examples. Additionally, they offered a global description of the solution-focused process of therapy. De Jong and Berg (2002) suggested that there are five stages to solution-focused therapy. The first stage involves obtaining a description of the problem. This step is much like "traditional" therapy in that the first meeting involves that client telling the story of the problem. However, this stage differs from "traditional" therapy in that fewer details about problem specifics and severity are requested. The therapist at this point merely allows the client to describe his/her problem story without much intervention. The second stage of solution-focused therapy involves the establishment of goals. Clients are asked to think about how their lives would be different if their problem was solved. From this imagery, specific goals for treatment are identified. The third stage of solution-focused therapy involves examination of the exceptions. Therapists at this point ask about situations in which their problem was less severe or absent along with

possible factors that may have contributed to such a reduction. The fourth stage of solution-focused therapy involves providing feedback to the client at the conclusion of the session. At this point the therapist can utilize compliments and suggestions to help the client through the time between sessions. The compliments function to emphasize the effective qualities already present in the clients actions, whereas the suggestions help the client identify specific ways to improve their situation further. Finally, the last stage in the solution-focused therapy process involves evaluating client progress. Throughout solution-focused therapy, attempts are made to monitor a client's situation throughout treatment. The most common method used is to ask the client to rate his/her progress on a scale of 0 to 10. In this manner, the therapist has a description directly from the client about his/her perceived success and current severity of the presenting problem (De Jong and Berg, 2002).

Throughout the protocol outlined by De Jong and Berg (2002), therapists utilize many therapeutic tools that are unique to solution-focused therapy or used infrequently in other forms of therapy. Two of these techniques include the scaling question and the miracle question.

The scaling question primarily involves the therapist asking the client to rate himself/herself on a specific dimension from 0 to 10. De Jong and Berg (2002) indicated that "Scaling is a useful technique for making complex aspects of the client's life more concrete and accessible to both practitioner and client" (p. 108). Although scaling questions may be used in an unstructured manner by more "traditional" therapists, the importance of the scaling question is deeply rooted in the evolution of solution-focused therapy. The inexact nature of language prevents therapists from truly understanding a client, as they unintentionally project their own meanings and experiences to the clients words. Therefore, what does it mean if a client says that he/she is "better" ? By utilizing

a numerical scale, clients can convey to therapists specific issues in a clearer manner than may occur though the use of only verbal descriptions. Specifically, this technique is an effective means in which to define the client's internal experience of emotion. The scaling question is also important in solution-focused therapy for its emphasis on client success. For example, if a client is asked to rate himself/herself on a scale where 0 stands for the worst the problem has ever been and 10 stands for complete elimination of the problem, any response other than 0 represents a successful movement toward problem resolution. Even if the client responds with a 1, the therapist may inquire about how the situation has improved from a 0 to a 1, through the course of examining exceptions to problems and reinforcing client success. De Shazer (1994) suggested that the scaling question may be used effectively with many types of populations including children, developmentally disabled adults, and "anyone who grasps the idea that 10 is in some way(s) 'better' than 0..." (p.94). Additionally, scaling questions can be used to examine a variety of concepts including but not limited to self-esteem, pre-session change, and depression (De Jong and Berg, 2002).

Another technique used in solution-focused therapy is the miracle question. Unlike the scaling question, the miracle question is not as commonly used in more "traditional" forms of therapy. This technique is implemented when the therapist asks the client what it would be like if he/she awoke the next morning and the presenting problem was miraculously solved. De Jong and Berg (2002) emphasized that the most effective use of this technique occurs when it is done in a dramatic and deliberate fashion. In that way, "the miracle question requests clients to make a leap of faith and imagine how their life will be changed when their problem is solved" (De Jong and Berg, 2002, p.85). In this manner, the emphasis of conversation is changed from a focus on problems to a focus on solutions. Additionally, de Shazer suggested that the miracle question initiates the

construction of "...a bridge between therapist and client built around the (future) success of the therapy" (de Shazer, 1994, p. 95). Along with promoting change in the therapeutic process, the miracle question promotes change outside of the therapy environment. The miracle question forces the client to focus on specific aspects of their environment, including other individuals, which may change when the problem is solved. It is likely that the client may observe those around him/her changing in the manner hypothesized through the miracle question as therapy progresses. This observation serves as a reinforcement and reminder of his/her success, even if only a partial success. Overall, the miracle question is a specific technique used in solution-focused therapy that places much emphasis on client competence.

Empirical Research on Competence-Based Therapies

Over the past 20 years, solution-focused therapy and narrative therapy have experienced substantial increased attention. Multiple books and journal articles have been written about the theoretical origins and application of specific techniques. However, there has been little empirical examination of the efficacy of these therapies. Miller and Duncan (2000) reported that research on the effectiveness of solution-focused therapy has been slow to develop. They also indicated that the sparse literature that is present suggests that solution-focused therapy displays generally equivocal effectiveness as compared to other mainstream forms of therapy, such as cognitive-behavioral therapy (Miller and Duncan, 2000). The absence of empirical examination is not limited to solution-focused therapy, as narrative therapy has yet to be extensively explored. Etchison and Kleist (2000) elaborated on the absence of empirical research examining narrative therapy. They reported that "Despite the apparent attraction to narrative therapy, research on its utility is sparse" (Etchinson and Kleist, 2000, p.61). These authors attempted to theorize the circumstances that have maintained this void of research

about narrative therapy. Although they directly addressed the absence of research on narrative therapy, their conclusions may provide insight about the overall lack of empirical investigation on competence-emphasizing interventions, including narrative therapy and solution-focused therapy. The first possible explanation offered by Etchinson and Kleist (2000) as to the absence of empirical research concerns the emphasis on constructivist thinking. These authors suggested that the focus on constructivism, by definition, prevents agreement with traditional aspects of research, such as objectivity, that are needed to produce outcome research (Etchinson and Kleist, 2000). The second reason for the absence of research in this area concerns researchers' bias against qualitative research. Etchinson and Kleist (2000) suggested that qualitative research rather than quantitative research may be best employed to explore competence-emphasizing interventions. These authors suggested that a lack of training in qualitative research and a lack of acceptance of qualitative research by major journals may each be contributing to this absence of research.

Despite the general absence of literature exploring the use of competence-emphasizing interventions, such as narrative therapy and solution-focused therapy, there are some published studies that attempt to initiate the comparison between such interventions and more traditional ones. Greene et al. (1996) addressed the possible improvements associated with introducing facets of solution-focused therapy to crisis intervention. This particular article is remarkable as the authors attempted to improve crisis intervention by introducing client competence thinking in an area that is consistently dominated by a more traditional, deficit approach. Greene et al. (1996) reported that many current crisis interventions function under the assumption that an individual's "coping mechanisms are inadequate to meet the challenge of the precipitating event" (p. 44). The authors contrasted this with the perspective offered by solution-

focused therapy that emphasizes client competence. Greene et al (1996) suggested that by changing the focus of intervention from one of deficits to one of strengths, the crisis intervention may be more effective. These authors specifically identified how the strength perspective of solution-focused therapy may be helpful with numerous common sources of crisis problems. These problem areas include domestic violence, harassment, grief, sobriety issues, and suicidality. Overall, Greene et al. (1996) indicated that they "believe that a solution-focused approach to crisis intervention is the treatment of choice in the majority of crisis situations" (p. 61). Although only exploring the issues theoretically, Greene et al. (1996) suggested that crisis intervention and solution-focused therapy fit together rather well. They reported that the strength development aspect is particularly helpful as crisis situations have been found to be good points to initiate personal development.

Research on Personality and Therapy Experience

Almost since the creation of psychotherapy, there have been multiple treatment modalities. However, the majority of these methods employ a deficit perspective. Some research has explored the interaction between personality dimensions and therapy modality for deficit-based interventions. With the recent advent of competence-based psychological interventions, there are many new forms of therapy available. However, at this time it is unclear how personality dimensions are related to the experience of competence-based interventions. The research presented here attempts to identify connections between personality dimensions and the experience of deficit- and competence-based therapy. Therefore, an understanding of the literature examining personality dimensions and therapy experience is necessitated.

Whereas some research explores how personality dimensions are altered during the course of psychological disorders (Bagby, Joffe, Parker, Kalemba, and Harkness,

1995), more relevant to this investigation is research examining how the personality factors present prior to therapy may impact the helping process. The research in this area has specifically examined how personality is related to pre-treatment preferences and treatment outcome.

Research has attempted to examine how pre-treatment preferences impact therapy. In a summary of information about client preferences, Manthei (1988) highlighted two specific problems encountered in this research: Client preferences are easily modified and specific characteristics of therapy may be inferred differently by different individuals. Therefore, Manthei suggested that the potential benefits of researching client preferences may be limited due to the changing nature of preferences and the inability of different clients to identify the presence of specific characteristics in therapy. Nevertheless, with an acknowledgment of these cautions, research examining client pre-treatment preferences can provide some limited information about how a client experiences therapy. Expectations of therapeutic experiences motivate pre-treatment preference. Therefore, individuals will choose a therapy that seems most likely to produce a desired therapy experience.

The research that has examined pre-treatment preferences has generally focused on either preferences for the form of treatment or preferences for specific therapist characteristics. A study by Cashen (1979) found that behavioral interventions were preferred over client-centered interventions by a non-clinical group of subjects. Cashen hypothesized that the subjects were attracted to the structure of the treatment involved in the behavioral approach. Dancey, Dryden, and Cook (1992) examined individual preferences for specific forms of treatment. Using a non-clinical population, these authors determined that cognitive-behavioral therapy was preferred most over a humanistic approach, psychoanalytic therapy, and a common sense approach.

These preference studies provide information about pre-treatment preferences in the absence of personality variables. Other pre-treatment research has been conducted examining the relationship between personality factors and choice of therapist. Mindingall (1985) found a link between personality and preference of therapist. She determined that potential clients identified as socially intimate preferred therapists who were also characterized as intimate. In this study personality dimensions were evaluated through the use of Levenson's Locus of Control Scale and a college version of the Intimacy Scale. Additionally, Hollander-Goldfein, Fosshage, and Bahr (1989) also examined personality variables and preference of therapist. In this study, personality dimensions were evaluated through the use of the Minnesota Multiphasic Personality Inventory, 16 Personality Factor Questionnaire, and Diamond Q-Sort. These authors concluded that personality variables were not found to be related to preference of therapist. They determined that other factors such as interpersonal attraction were more substantial factors mediating client preference. A more recent study was conducted by Heaven and Furnham (1994) who examined how personality factors may affect preference for treatment for depression. In this study, the Eysenck Personality Questionnaire was used to evaluate personality dimensions. The participants in this study were instructed to imagine that they were experiencing symptoms of depression. They were each asked to provide information about their preferences for 22 different forms of therapy. The results concluded that individuals high in extroversion and neuroticism personality traits were more likely to prefer cognitive and behavioral therapies. There were no other connections between other personality dimensions and preferences for forms of therapy (Heaven and Furham, 1994). Overall, research has attempted to determine how personality and preference are connected. However, this research examining client preference has yet to establish strong links between personality

dimensions and pre-treatment preferences.

Along with exploration of the impact of personality on pre-treatment preferences, researchers have also attempted to better understand the therapeutic process through the connection between personality factors and treatment outcome. As might be assumed, the increased emphasis on accountability that has arrived with managed care has promoted the development of numerous outcome studies. Many of these studies have attempted to examine how personality factors are related to specific treatment outcomes. Such studies have investigated this connection in the treatment of various psychological disorders. The literature that examines this connection as it relates to treatment for depression offers a representative example of the entire body of research. This literature is especially relevant as multiple treatments of depression will be considered in the study reported here.

Among the many personality variables explored as being possibly related to outcome, two of the most examined personality dimensions are sociotropy and autonomy as described by Beck, Epstein, and Harrison (1983). Sociotropy is defined as "the social dependent dimension" and individuals high in this dimension have strong interests in obtaining and continuing interpersonal relationships. Autonomy is described as "the self-critical dimension" and individuals high in this dimension have strong beliefs about independence and personal achievement (Zettle, Haflich, and Reynolds, 1992, p.788). Zettle et al. (1992) suggested that these dimensions are particularly relevant in the origination and presentation of depression. They conducted a study examining how sociotropy and autonomy are related to depression. They utilized the Sociotropy-Autonomy Scale to assess personality dimensions in 59 individuals seeking services for depression. It was concluded that for individuals high on the sociotropic dimension more successful treatment and greater symptom reduction was experienced in group therapy

than in individual therapy. Additionally, for individuals high on the autonomy dimension, greater symptom reduction was experienced in individual therapy than in group therapy. Thus Zettle et al. (1992) determined that specific personality factors may interact with treatment modality to affect overall outcome. A similar study was conducted by Scott, Harrington, House, and Ferrier (1996). They also utilized the Sociotropy-Autonomy Scale to assess personality dimensions in 26 individuals seeking treatment for depression. These authors concluded that higher autonomy scores were related with lower symptom severity after administration of a pharmacological intervention. Individuals high on sociotropy did not experience a similar reduction in symptoms. These authors suggested that the personality dimensions of sociotropy and autonomy may be related to response of treatment with antidepressant medication.

Sociotropy and autonomy as outlined by Beck et al. (1982) are not the only personality dimensions examined in relation to treatment outcomes. Burns, Rude, Simons, Bates, and Thase (1994) specifically looked at the personality dimension of learned resourcefulness. These authors found that individuals who scored high on learned resourcefulness, as measured through the Self-Control Schedule, were generally those that improved the most over the course of treatment. Additionally, they found that high learned resourcefulness scores were chiefly predictive of treatment success in severely depressed patients. A more recent study by Mynors-Wallis and Gath (1997) examined the connection between multiple personality dimensions and treatment outcome for individuals with major depression. These authors specifically examined neuroticism through the use of the Eysenck Personality Questionnaire, self-control through the use of the Self-Control Schedule, and self-appraisal through the use of the Problem-Solving Inventory. Their results suggest that none of these personality factors were related to outcome of treatment (Mynors-Wallis and Gath 1997). Overall, research has found some

specific personality factors, such as sociotropy, autonomy, and learned resourcefulness, to be significantly related to depression treatment outcome whereas other personality factors, such as neuroticism, self-control, and self-appraisal of problem solving ability, were not found to be related to outcome.

The research that has examined the connection between personality and outcome in addition to the research that examined personality and pre-treatment preferences each provide a small piece of information about how personality is related to the experience of therapy. How personality relates to the emotions, thoughts, and behaviors that occur during therapy has yet to be empirically evaluated. The absence of literature that specifically examines how personality factors are related to therapy experience forces the use of other literature, such as preference and outcome literature, to infer information about therapy experience. These studies provide some insight about the therapy experience. The literature examining client preference often concluded that individuals view specific treatments or therapists as more advantageous. Thus, it may be inferred that individuals have specific ideas about what they would like therapy to be. Additionally, the research on personality and treatment outcome concluded that specific personality dimensions are related to improved outcomes. Such results may suggest that certain personality dimensions are more congruent with certain therapy experiences. Admittedly, the inferences about therapeutic experience obtained from research on preference and outcome is speculation at best and should be made with caution. Nevertheless, the reliance on these forms of research to infer information about therapeutic experience clearly highlights a void in the current psychological research literature.

Although there have been very few studies that examined therapeutic experience, a study by Nelson and Stake (1994) specifically examined perceived quality of the therapy relationship and personality dimensions. These authors administered the Myers-

Briggs Type Indicator to both clients and therapists. An additional questionnaire was also administered to determine the quality of the therapy relationship. This dimension was assessed through the adaptation of items from the Patient Questionnaire. Participants were asked to rate their level of agreement on a seven point Likert scale to ten statements about the therapeutic relationship. The results of this study indicate that clients' perceptions of quality were positively related to the similarity of Myers-Briggs Type Indicator profiles between clients and therapists (Nelson and Stake 1994). These results provide some information about how personality dimensions are related to therapy experience insofar as perceived quality of the therapeutic relationship represents an aspect of that experience. Although this study provides some insight into the connection between personality and therapy experience, more research is needed to better understand this complex interaction.

Statement of the Problem

Throughout the past 20 years, a growing emphasis on competence has been building within the psychotherapy literature. Additionally, this emphasis has led to the creation of specific therapeutic interventions primarily based on a competence approach, such as narrative therapy and solution-focused therapy. These interventions offer a distinct alternative to traditional deficit interventions. However, the competence-based interventions have progressed directly from theory to practice without much empirical evaluation or support. This void of research includes the specific absence of studies comparing how clients experience deficit-based interventions to how clients experience competence-based interventions. Furthermore, research has determined how some personality dimensions relate to the experience of deficit-based interventions. However, there is an absence of literature exploring how personality relates to competence-based interventions.

The study discussed here provides some information about how personality dimensions are related to the experience of therapy. This study directly compared the experience of a competence model of helping, solution-focused therapy, with the experience of a deficit model of helping, cognitive therapy.

Study Hypotheses

The purpose of this study was to examine the relationship between client personality and the experience of two different forms of therapy. The hypotheses for this study were as follows:

1) Previous research has determined that the use of cognitive-behavioral therapy is more effective for individuals with high scores on the MCMI-II dependent and compulsive scales (Rathus et al. 1996) in the treatment of panic disorder. These authors concluded that cognitive-behavioral therapy was most effective for these individuals because it provided an environment high in discipline and organization. According to this conclusion, it may be assumed that individuals with high scores on the dependent and compulsive scales would show greater satisfaction with a cognitive therapy for other psychological problems. Since cognitive therapy contains more structure and direction from the therapist than solution-focused therapy, it was hypothesized that individuals with high scores on the dependent and compulsive scales would report a therapy preference for cognitive therapy.

2) Due to the lack of empirical investigations of competence-based therapies, the conceptual connections between personality characteristics and solution-focused therapy were used to generate a hypothesis about the preference for solution-focused therapy. Two of the keys to solution-focused therapy involve the utilization of personal resources and the exploration of the subjective reality specific to the client. Individuals high on the histrionic and narcissistic scales of the MCMI-II may have personality dimensions

congruent with these tenets of solution-focused therapy. Therefore, it was hypothesized that individuals high on the histrionic and narcissistic dimensions would report a preference for solution-focused therapy.

3) It is assumed that the current prevalence of deficit-based orientations in psychology have affected individuals' views of therapy as a whole. Deficit-based interventions are generally the forms of therapy most often presented in the mass media. Individuals with limited knowledge of the psychotherapy process may infer that such interventions are the most common and most effective methods for psychological improvement. Due to this prevalence and exposure of deficit-based therapy, it was expected that participants may believe that therapy must focus on "fixing" something that is "broken." Therefore, it was hypothesized that participants would indicate that the cognitive therapy would be more effective than the solution-focused therapy.

4) Due to the nature of solution-focused therapy, there is a strong emphasis on optimism and the capacity of individuals to deal with their own problems. Additionally, the structure of the solution-focused therapy session may appear less formal and more conversational than cognitive therapy. Therefore, it was hypothesized that when participants are asked to assume that both forms of intervention are equally effective, they would report that they would prefer to participate in solution-focused therapy rather than cognitive therapy.

CHAPTER II

METHOD

The sample used in this study was comprised of undergraduate students from psychology courses at the University of North Dakota. These individuals were presented with two separate vignettes of different forms of therapy. After viewing the first vignette, participants completed self-report measures about their perceptions of the therapeutic intervention they observed. Following the second vignette, the same measures were administered in order to evaluate the second observed intervention. Participants also completed measures directly comparing both vignettes. Finally, participants completed the MCMI-II to investigate characteristics of their personalities.

Participants

One hundred seventeen students, enrolled in psychology courses at the University of North Dakota served as participants in this study. These individuals ranged in age from 18 to 31 with a mean age of 19.4 years and a median age of 19.0 years. Of the sample, 42 (35.9%) were men and 75 (64.1%) were women. Each of the participants received extra credit for their participation.

Instruments

Therapeutic Techniques. The Therapeutic Techniques scale was part of the post-vignette measures. It was used as a validity check for the vignettes. This measure specifically asked participants to report the therapist activities observed on the vignettes. Items from this scale were adapted from the therapeutic preference measure developed by Dancey et al. (1992). This scale was originally developed to assess what individuals

would like to occur in a hypothetical therapy situation. This scale contains 12 items: 3 representing cognitive-behavioral activities, 3 representing humanistic activities, 3 representing psychodynamic activities, and 3 representing common-sense activities. Participants are asked to report their desire for each activity by responding to each item on a 7-point Likert scale, ranging from "Not at all" to "To a great extent." Through careful alterations, this scale may be used to assess the presence or absence of the same activities in the presented vignettes.

There were two alterations made to this measure. The first alteration involved changing the instructions for the scale. The original instructions were "Irrespective of how you think your (therapist) counselor will try to help you, to what extent would you prefer that she (he) will help you by..." (Dancey et al, 1992, p. 224). These instructions were changed to "Imagine that you were the client in the vignette, to what extent did the therapist help you by..." The other alteration of the original scale involved the replacement of an item describing humanistic activities with an item that is consistent with a solution-focused intervention. As previously discussed, solution-focused therapy has many similarities to humanistic interventions. The items describing the humanistic activities have much conceptual overlap with solution-focused therapy. Therefore, in order to most accurately assess the solution-focused therapy vignette, one of the humanistic items that was inconsistent with solution-focused therapy was replaced. This new solution-focused item specifically focuses on the identification and utilization of personal resources, a central theme in solution-focused therapy. The other two humanistic items were not altered because they expressed ideas highly consistent with solution-focused therapy. The items presenting the psychodynamic and common-sense activities were not a primary focus of this study. A copy of this measure may be found in Appendix A.

Expected Outcomes. This scale was part of the post-vignette measures. It was specifically designed for this study and used to assess the participants' expected outcomes of the presented forms of therapy. It contained three items that asked the participant to speculate about the consequences of the therapy viewed in the vignette. Participants were asked to respond to each item on a 7-point Likert scale ranging from "Very Much" to "Not At All." The items asked the participant to imagine he/she was the client in the vignette. A copy of this measure may be found in Appendix B.

Experience. This scale was part of the post-vignette measures. It was specifically designed for this study in order to assess the experience of therapy. It contained twenty-three items that asked about the affective, cognitive, and behavioral experiences of therapy. Participants were asked to respond to each item on a 7-point Likert scale ranging from "Very Much" to either "None at all" or "Not At All." For each of the items on this scale, the participant was asked to imagine that he/she was the client in the vignette. A copy of this measure may be found in Appendix C.

Demographic information. This questionnaire was part of the follow-up measures. It was used to obtain basic information about the participants. Specifically, this measure asked for the participants' age and gender. Additionally, this measure asked participants about their previous experience with therapy. Participants were asked if they had ever participated in any form of therapy, with what type of helper, and how long the therapy lasted. A copy of this measure is included in Appendix D.

Preference. This scale was part of the follow-up measures presented to participants after viewing both vignettes. This scale was designed specifically for this study to measure the participants' choice of videos. Participants were asked to indicate choice on a 7 point Likert scale. The extreme poles of this Likert scale represented strong

preference for either vignette 1 or vignette 2, whereas the middle point of the scale represented no preference. One item specifically asked which form of therapy was thought to be most effective. The other item asked about preference, assuming equal effectiveness. A copy of this measure is included in Appendix E.

The Millon Clinical Multiaxial Inventory-II (MCMI-II). This scale was used as a follow-up measure, administered after the participants viewed both vignettes. The MCMI-II is a clinical assessment inventory designed to measure psychological characteristics according to the definitions outlined in the DSM-III-R. It was utilized in this study to measure personality dimensions that are consistent with Axis II diagnoses. There are numerous personality characteristics that could have been explored in relation to therapeutic experience. However, many of these personality characteristics are peripheral to the helping process and are not directly relevant in therapy. For example, personality factors such as warmth, conformity, and shrewdness are generally not assessed in a therapeutic exchange. However, histrionic, schizoid, and dependent characteristics are personality dimensions routinely assessed within therapy. Therefore, the MCMI-II was used as a measure to evaluate personality characteristics associated with Axis II disorders that are highly pertinent for therapeutic interactions.

The MCMI-II contains 175 true/false items and produces scores on 10 personality styles, 3 areas of personality pathology, 6 clinical syndromes, and 3 severe clinical syndromes. The MCMI-II also contains 3 validity scales used to adjust the scores on the personality and syndrome scales. Scores on each of these scales are given as base rates. Such base rate scores are often used to determine the presence or absence of specific personalities or syndromes. For example, a base rate higher than 75 on the antisocial scale is indicative of the presence of antisocial personality traits. Nevertheless, the base rate scores may also be used in a dimensional fashion. Rathus, Sanderson, Miller, and

Wetzler (1995) suggested that it is more useful to examine MCMI-II results as dimensions rather than as categories. For use in this study, the MCMI-II base rates were interpreted statistically as personality dimensions rather than either/or indicators of the presence of psychological diagnoses.

The psychometric qualities of the MCMI-II are fairly strong. Correlation coefficients highlighting the reliability of the MCMI-II were found to range from .78 to .91 in a non-clinical population with the administrations occurring between three and five weeks (Millon, 1987). Additionally, the validity is also within the acceptable range. Millon (1987) reported that in a sample of 703 patients, diagnoses made from a clinical interview agreed with MCMI-II elevations for 90-98% of the cases. Specific validity information about the use of MCMI-II base rates, rather than scale profiles, was not available.

The MCMI-II was chosen to be used in this study over the more current MCMI-III for two reasons. First, the MCMI-II was used in other studies attempting to examine how personality dimensions may affect therapy. Studies such as the one conducted by Rathus et al. (1995) are very similar to the study described here. Second, the current literature offers mixed support for the use of the MCMI-III. For example, Craig and Bivens (1998) suggested that the factor structure of the MCMI-III is very similar to the MCMI-II. However, Peterson (1999) concluded that the MCMI-III actually has a factor structure that is separate and diverse from the MCMI-II. Overall, the use of the MCMI-II in past research and the disagreement over factor structure of the MCMI-III offer support for the use of the MCMI-II in the study presented here.

Therapy Vignettes

There were two vignettes created specifically for this study. One vignette portrayed cognitive-behavioral therapy whereas the other vignette portrayed solution-

focused therapy. Except for the method of therapy, each of the videos was created as to minimize the amount of differences between them. Therefore, each vignette involved the same actors, same environment, and same presenting problem. Each video was created to be approximately the same length. The solution-focused video lasted 26 minutes and the cognitive therapy video was 31 minutes long.

Each of the vignettes showed a treatment session with a 19-year-old, Caucasian woman who was experiencing symptoms of depression. She was identified as a mother of two young children who had been removed from her custody. Additionally, the client had been in a romantic relationship that had become abusive. The model for this client was adapted from the case study offered by Berg and De Jong (1996).

Solution-Focused Therapy Vignette. This vignette showed one session of solution-focused therapy. It was developed from a transcript published in an article by Berg and De Jong (1996). For instructional purposes, this article contains a thorough transcript of an initial session of solution-focused therapy. The ethnicity of the client was changed from African-American to Caucasian to make the vignettes of therapy more consistent with the pool of participants used in the study. No other modifications were made to the transcript to alter demographic information or specific details related to the presenting problem. The instructional text that was published within the reprinting of this case study was removed and the session was used verbatim from this article. A copy of the transcript for this vignette is included in Appendix F.

Cognitive Therapy Vignette. This vignette showed one session of cognitive therapy. It was developed by adapting the client and presenting issue from the article by Berg and De Jong (1996) to a session with a cognitive focus. This was done by creating a fictional cognitive therapy session through the methods described by Beck (1995). Upon the completion of this transcript, it was evaluated by two licensed clinical psychologists.

These individuals were identified as having a strong understanding of cognitive therapy. Their input suggested only minor changes that were applied to the hypothetical therapy session. This evaluation ensured that the actual delivery of cognitive therapy was not compromised through the adaptations that were made. A copy of the transcript for this vignette is included in Appendix G.

Procedure

Participants were initially asked to complete the pre-vignette measures, which included the consent form for this study. A copy of the consent form is included in Appendix H. Participants were then shown one of the therapy vignettes. The order of the vignette presentation was counterbalanced in order to control for effects related to the order of presentation. Fifty-nine participants saw the cognitive therapy video first and 58 saw the solution-focused therapy video first. Following the presentation of the first therapy vignette, each participant completed the post-vignette measures. Upon completion of these self-report questionnaires, the participants were presented with the other therapy vignette. Participants were asked to complete a duplicate copy of the post-vignette measures following the presentation of the second vignette. Finally, for the last portion of this study, participants were asked to complete the follow-up measures. This study was conducted in small groups of participants, ranging in size from 4 to 15 participants. Approximately 90 minutes was needed for the participants to complete the tasks involved in this study. The procedure of this study is diagrammed in Figure 1.

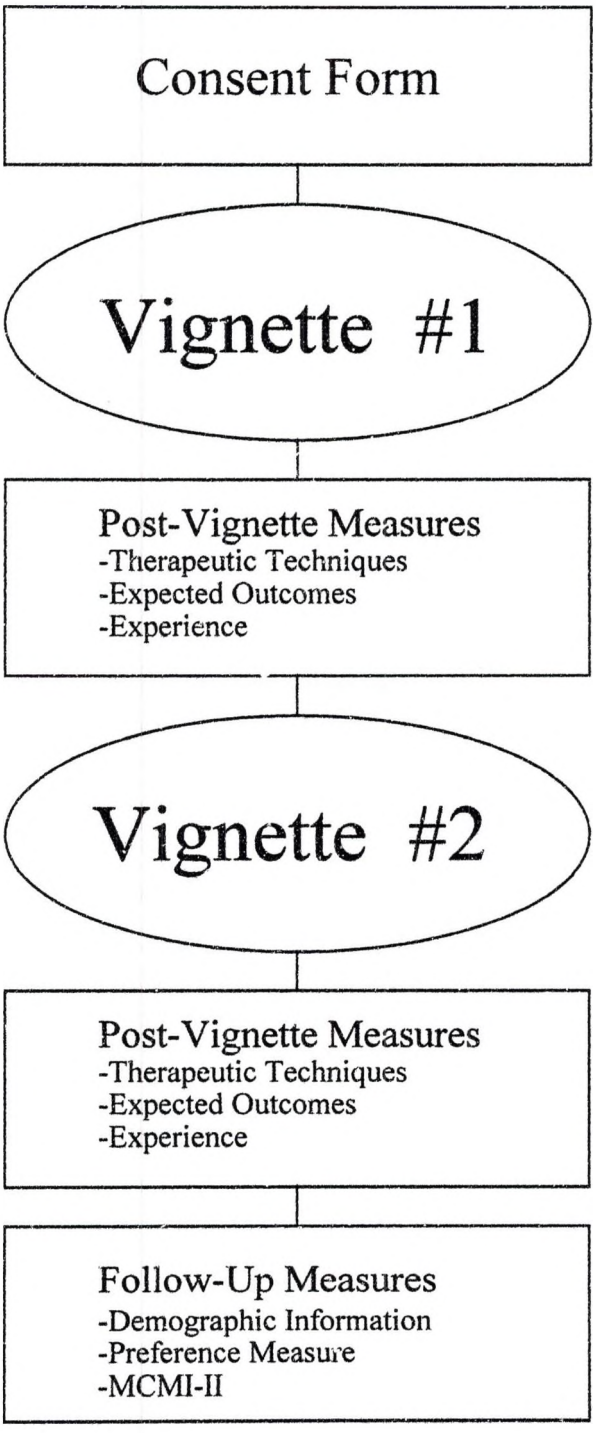

Figure 1. The structure of this study with information about the measures used and their points of administration.

CHAPTER III

RESULTS

The results are presented in five parts. First, analyses are provided to determine if the perception of the therapies in the videos was consistent with the characteristics of the therapies. Second, the analyses comparing the perceived experience of cognitive therapy with the perceived experience of solution-focused therapy are described. Third, the four identified hypotheses of this study are evaluated. Fourth, additional analyses are presented that investigated how the perceived experience of each form of therapy was related to perceived effectiveness, preference, and expected outcomes. Finally, analyses are described that separately examined the participants with a history of involvement in therapy and those without such a history.

Perception of Therapy Videos

In order to examine how each of the therapy videos was perceived, participants were asked to complete a measure rating the presence of the characteristics from four different forms of therapy. This measure may be found in Appendix A. Included within these types of therapy were cognitive therapy and solution-focused therapy, the forms of therapy utilized in this study. Additionally, the measure also included characteristics consistent with a common-sense approach and a psychoanalytic approach to therapy.

Participants were asked to complete this measure twice, once immediately following the presentation of each video.

Each of the four types of therapy being investigated was represented by three items on this measure. Participants were instructed to respond in a manner indicating the degree to which the characteristic was present in the immediately preceding video. The ratings of these measures were converted to numerical values. The mean values and standard deviations for each of the 12 items on this scale may be found on Table 1. To facilitate analysis, the numerical values for each of the three items representing each of the four types of therapy were added together. Thus each type of therapy was rated on an overall scale of 0 (characteristics consistent with that type of therapy are absent) to 21 (characteristics consistent with that type of therapy are fully present).

Cognitive therapy. This study was conducted under the assumption that the cognitive therapy video accurately represented an intervention consistent with cognitive therapy. This assumption was empirically examined by comparing the cognitive therapy ratings for the cognitive therapy video and the solution-focused video. Such ratings were evaluated through the use of a t-test. The result suggests that the cognitive therapy video (15.98) had a higher rating on the measure of cognitive therapy characteristics than the solution-focused video (8.56). This difference was found to be significant $t(115) = 14.093$, $p = .000$.

Solution-focused therapy. In addition to the assumption associated with the cognitive therapy video, a companion assumption was utilized in this study concerning the solution-focused video. It was assumed that the solution-focused video accurately represented an intervention consistent with solution-focused therapy. This assumption

Table 1. Mean and Standard Deviations for Therapeutic Technique Items

Techniques	Cognitive Video	Solution-Focused Video
Solution-Focused		
Item 1	5.18 (1.46)	3.81 (1.59)
Item 7	4.84 (1.54)	3.87 (1.78)
Item 9	4.94 (1.52)	4.21 (1.76)
Cognitive		
Item 3	5.39 (1.62)	2.74 (1.59)
Item 5	5.02 (1.46)	2.81 (1.65)
Item 12	5.59 (1.42)	3.01 (1.61)
Psychoanalytic		
Item 4	4.13 (1.73)	3.15 (1.57)
Item 8	5.70 (1.52)	3.21 (1.83)
Item 10	4.70 (1.72)	4.21 (1.90)
Common Sense		
Item 2	5.24 (1.54)	3.67 (1.79)
Item 6	5.09 (1.54)	3.30 (1.88)
Item 11	4.95 (1.54)	3.03 (1.74)

was initially examined through the inspection of the means of the solution-focused ratings for the solution-focused therapy video and the cognitive therapy video. These statistics indicated that the mean solution-focused ratings were actually higher for the cognitive therapy video (15.00) than the solution-focused therapy video (11.91). A t-test determined that the rating of solution-focused techniques was significantly higher for the cognitive therapy video than the solution-focused video, $t(113) = 5.879$, $p = .000$. This is inconsistent with the assumptions of this study.

These results may suggest that the video presentation of solution-focused therapy was inaccurate. However, further inspection of the therapeutic technique ratings from the solution-focused video provides additional information. Examination of the mean ratings of the four therapeutic ratings for the solution-focused therapy video (see Table 2) reveals that the mean solution-focused rating was the highest value of the four types of therapy being rated. Additional inspection of this data also highlights that not only did solution-focused therapy obtain the highest ratings but cognitive therapy obtained the lowest. Such results suggest that the solution-focused video may have been most like solution-focused therapy and least like cognitive therapy.

The apparent difference between the solution-focused rating and the other three ratings was empirically examined. A one-way analysis of variance was conducted. It was determined that there were significant differences among the four therapy ratings, $F(3, 462) = 11.424$, $p = .000$. A Tukey HSD test was used to specifically examine this significant difference. The solution-focused rating was found to be statistically different from both the common sense ratings ($p = .006$) and the cognitive therapy ($p = .000$). Solution-focused ratings were not found to be significantly different from psychoanalytic

Table 2. Mean Therapeutic Technique Ratings for the Solution-Focused Video

Therapeutic Techniques	Mean Values (Standard Deviation)
Solution-Focused	11.91 (4.21)
Cognitive	8.56 (4.31)
Psychoanalytic	10.56 (4.46)
Common Sense	10.00 (4.71)

ratings ($p = .093$). Nevertheless, the preceding results suggest that the solution-focused video was best described according to the solution-focused items from the therapeutic technique scale, thus indicating that the solution-focused therapy video displayed characteristics most consistent of all the forms of therapy rated with a solution-focused approach to therapy.

Comparison of Perceived Experience

Before addressing the hypotheses, it will be informative to describe how the participants experienced the two forms of therapy. In order to do so, direct comparisons were made between the perceived experience of solution-focused therapy and the perceived experience of cognitive therapy. Each of the 23 experience items was used as an independent measure of perceived experience. Higher scores on each item indicated a stronger identification with that particular item. Results for these items are presented in Tables 3-5. Twenty-three paired t-tests were conducted to directly examine the experience ratings associated with solution-focused therapy with those associated with

cognitive therapy. In order to control for Type I error, the alpha level was corrected for 23 statistical analyses. Specifically, the threshold for significance was adjusted from .05 to .002 (.05/23 = .002). Such adjustment ensured that through the 23 analyses, the global risk of a Type I error remained at an acceptable level of .05.

The eleven affective experience measures were evaluated and produced results supporting the positive experience of cognitive therapy. Eight of the eleven affective ratings produced significant results. Specifically, cognitive therapy was found to be rated significantly higher than solution-focused therapy on assessments of "Feeling comfortable," "Feeling relieved," "Feeling listened to," "Feeling understood," and "Feeling eager to continue" during therapy. Further, solution-focused therapy was found to be rated significantly higher than cognitive therapy on assessments of "Feeling frustrated," "Feeling stressed," "Feeling defensive," and "Feeling dependent." Each of these ratings portrays cognitive therapy in a positive manner as compared to solution-focused therapy. This information is summarized in Table 3.

The analyses evaluating the cognitive experience of both solution-focused therapy and cognitive therapy produced results similar to those of the affective experience items. All of the seven cognitive ratings produced significant results. Specifically, cognitive therapy was found to be rated significantly higher on the items that assessed "Thinking of your problem in a new way," "Developing insight about your problem," "Learning more about your own abilities," "Being able to identify and conceptualize your problem," "Being challenged by the interaction in therapy," "Thinking that your time in therapy was productive," and "Examining yourself and your current problem situation." All of these

Table 3. Means (Standard Deviations) of Perceived Affective Experience Factors

Experience Factor	Cognitive Therapy	Solution-Focused Therapy
"Feeling Comfortable"	5.21 (1.52)	4.02 (1.83)*
"Feeling Frustrated"	3.21 (1.52)	4.42 (1.87)*
"Feeling Stressed"	2.97 (1.29)	4.07 (1.67)*
"Feeling Relieved"	5.03 (1.52)	3.67 (1.80)*
"Feeling Defensive"	2.90 (1.51)	3.79 (1.87)
"Feeling Dependent"	3.84 (1.42)	3.43 (1.48)*
"Feeling You Were Listened To"	5.95 (1.30)	4.79 (1.88)*
"Feeling You Were Understood"	5.74 (1.34)	4.57 (1.77)*
"Feeling Eager To Continue"	5.28 (1.64)	3.71 (1.96)*
"Feeling You were Being Controlled"	2.89 (1.56)	3.32 (1.73)
"Feeling Your Ideas were Validated"	4.97 (1.57)	4.44 (1.55)

*Indicates a significant difference. After correction, $p < .002$ for significance.

results indicate that the experience of cognitive therapy was more positive than the experience of solution-focused therapy. This information is summarized in Table 4. The analyses examining the behavioral experience of both solution-focused therapy and cognitive therapy also supported the positive perceptions of the cognitive therapy experience. Four of the five behavioral experience ratings produced significant results.

Table 4. Means (Standard Deviations) of Perceived Cognitive Experience Factors

Experience Factor	Cognitive Therapy	Solution-Focused Therapy
"Thinking of Your Problem In a New Way"	5.73 (1.28)	3.27 (1.59)*
"Developing Insight About Your Problem"	5.74 (1.26)	3.66 (1.75)*
"Learn More About Your Own Abilities"	5.55 (1.36)	4.10 (1.71)*
"Be able to Identify and Conceptualize Your Problem"	5.67 (1.24)	4.06 (1.69)*
"Be Challenged by the Interaction in Therapy"	4.91 (1.41)	3.46 (1.70)*
"Think that Your Time in Therapy Was Productive"	5.52 (1.61)	3.38 (2.00)*
"Examine Yourself and Your Current Problem Situation"	5.82 (1.31)	4.56 (1.76)*

*Indicates a significant difference. After correction, $p < .002$ for significance.

Specifically, cognitive therapy was found to have significantly higher ratings on measures assessing "How much would you have been able to say what you wanted during therapy," "How much would you have been able to listen during therapy," "How much would you have been able to remain physically comfortable," and "How much would you have been able to share difficult information with the therapist." The results of each of these items

further support the positive perceptions of the experience of cognitive therapy. This information is summarized in Table 5.

All of the 19 previously identified statistically significant results describe a more positive experience for cognitive therapy than for solution-focused therapy. Further, this statistical significance was present despite the stringent threshold for statistical significance utilized in order to prevent statistical error. Therefore, the results of these experience analyses overwhelmingly support the positive perceptions of cognitive therapy as compared to solution-focused therapy.

Exploration of Hypotheses

Hypotheses 1 and 2: Personality and preference. Because cognitive therapy contains more structure and direction from the therapist than solution-focused therapy, it was hypothesized that participants with higher scores on the dependent and/or compulsive scales on the MCMI-II would report therapy preferences for cognitive therapy over solution-focused therapy. It was also hypothesized that because solution-focused therapy emphasizes a subjective reality and personal resources that individuals scoring high on the histrionic and narcissistic scales from the MCMI-II would express a greater preference for solution-focused therapy than cognitive therapy.

These hypotheses were empirically investigated through the use of one multiple regression. The ten clinical personality patterns of the MCMI-II were used for independent variables. As mathematical constraints prevent the use of all of the MCMI-II scales in this statistic, only the 10 clinical scales were used. These were chosen over the remaining scales because they may more accurately represent the personalities of the participants involved with this study. The item that asked participants to rate their

Table 5. Means (Standard Deviations) of Perceived Behavioral Experience Factors

Experience Factor	Cognitive Therapy	Solution-Focused Therapy
"How Much Would You Have Been Able to Say What You Wanted During Therapy"	5.38 (1.47)	4.65 (1.94)*
"How Much Would You Have Been Able to Listen During Therapy"	5.20 (1.42)	4.00 (1.62)*
"How Much Would You Have Been Able to Maintain Eye Contact"	4.75 (1.68)	4.15 (1.72)
"How Much Would You Have Been Able to Remain Physically Comfortable"	4.94 (1.52)	4.06 (1.70)*
"How Much Would You Have Been Able to Share difficult Information with the Therapist"	4.91 (1.57)	3.95 (1.85)*

*Indicates a significant difference. After correction, $p < .002$ for significance.

preference for either form of therapy on a Likert scale was used as the dependent variable. The analysis utilized a stepwise method of multiple regression. R for regression was significantly different from zero, $F(1, 115) = 5.013$, $p = .027$

Only one independent variable, schizoid personality (sr_i^2 = -.204), contributed significantly to the prediction of preference for cognitive therapy or solution-focused therapy. According to this relationship, higher schizoid tendencies were associated with a greater preference for solution-focused therapy. Altogether, only 4% (R^2 = .042), 3% adjusted (Adjusted R^2 = .033), of the variability was predicted by schizoid personality. Thus, even though characteristics of schizoid personality were found to be associated with a preference for solution-focused therapy, it was not a strong predictor of preference.

Even though the predicted scales associated with hypothesis 1 and hypothesis 2 were not entered as significant predictors, they were individually examined further. Hypothesis 1 suggested that participants with higher scores on the dependent or compulsive scales would prefer to participate in cognitive therapy more than solution-focused therapy. This hypothesis was not supported in this study. The level of significance for the compulsive scale (beta = .065) was far from approaching inclusion in the multiple regression equation (p = .500). In addition, the statistic for dependent personality (beta = .134) also was not large enough to be entered into the equation, p = .149. Nevertheless, this independent variable approached the threshold of significance where it would be entered into the equation, and the direction of the association was as predicted, i.e., individuals scoring high on the dependent personality measure generally preferred cognitive therapy. However, this still provides little evidence to support the hypothesis.

Hypothesis 2 suggested that participants with higher scores on the histrionic and narcissistic scales would prefer solution-focused therapy. This hypothesis was not confirmed. Scores from the histrionic scale (beta = -.067) of the MCMI-II were not found

to be significantly associated with preference of therapy type ($p = .538$). Scores from the narcissistic scale (beta = -.164) were also not found to be significantly associated with a preference of therapy type ($p = .093$). Nevertheless, this variable also approached the threshold of significance where it would be added into the equation describing preference of therapy. The direction of the association was as predicted, individuals scoring high on the narcissistic personality measure generally preferred solution-focused therapy. However, this provides little evidence to support the hypothesis.

Hypothesis 3: Perceived effectiveness. It was hypothesized that the current prevalence of deficit-based interventions would lead participants to respond in a manner indicating cognitive therapy to be more effective than solution-focused therapy. One of the items administered following the presentation of both therapy videos was designed to measure perceived effectiveness. Participants were asked to respond to this item on a seven point Likert scale. Extreme preference for cognitive therapy was scored a "7", extreme preference for solution-focused therapy was scored a "1", and a rating of "4" was considered to be an indication of perceived equal effectiveness.

The mean value on this measure was 5.59. According to the construction of the scale, this value represents greater perceived effectiveness of cognitive therapy as compared to solution-focused therapy. A t-test was utilized to determine if this value was significantly different from the value that represented equal effectiveness, 4. This statistic was found to be significant, $t(116) = 9.895$, $p = .000$. These results indicate that participants in this study reported that cognitive therapy was perceived to be more effective than solution-focused therapy, supporting the hypothesis.

Hypothesis 4: Overall preference. An additional hypothesis was generated suggesting that the strong emphasis on optimism and the conversational nature of solution-focused therapy would make it more preferable than cognitive therapy to the participants when asked to assume that each type of intervention was equally effective. One of the items administered following the presentation of both therapy videos was intended to measure preference, assuming equal effectiveness. Participants were asked to respond to this item on a seven point Likert scale. Extreme preference for cognitive therapy was associated with a "7", extreme preference for solution-focused therapy was given a "1", and a response indicating equal preference was scored a "4".

The mean value on this measure was 5.41. A value of this magnitude is consistent with a preference for cognitive therapy. A t-test was performed in order to determine if this value was significantly different from 4, the value representing no preference. This statistic was found to be significant, $t(116) = 7.777$, $p = .000$, indicating participants found cognitive therapy to be more preferable than solution-focused therapy, assuming equal effectiveness. This is contrary to the hypothesis.

The instructions for the item examining overall preference asked the participants to assume equal effectiveness of both forms of therapy. Nevertheless, to obtain additional information about these dimensions, the relationship between perceived effectiveness and overall preference was examined. A Pearson correlation was computed, showing that perceived effectiveness was significantly correlated with overall preference, $r(115) = .864$, $p < .01$. Thus, there may have been a strong tendency for participants who rated one form of therapy as more effective to also show preference for that form of therapy. An

alternative explanation is that this strong correlation suggests the measures of overall preference and perceived effectiveness were actually assessing the same dimension.

Additional Analyses

Statistical Procedures for the Additional Analyses. As a complement to the analyses directly investigating this study's hypotheses, a series of multiple regressions was conducted to explore the role of perceived experience of therapy. The experience measure consisted of 23 items that inquired about the perceived affective, cognitive, and behavioral experiences of therapy. Each of the items from the measure of experience constituted a single, specific factor that was to be used as an independent variable in the multiple regressions. Due to statistical restraints related to the size of the sample in this study, a multiple regression conducted with all 23 factors as independent variables would artificially increase the likelihood of producing significant results. Therefore, an additional statistical protocol was utilized to examine the role of perceived experience of therapy more appropriately.

A publication by Stevens (2001) described a procedure to avoid such an artificial inflation of significant results. This author suggested splitting the data file in two equal groups and running the same statistical procedures with both data groups – effectively replicating the study to remove error. For these additional analyses, statistical computer software was used in order to randomly split the data file into two equal portions. As there were 117 participants in this study, the first data split, Group 1, had 58 participants and the second data split, Group 2, had 59 participants. Equivalent statistical procedures were conducted with both Group 1 and Group 2. Specifically, multiple regressions were conducted with all 23 of the factors from the experience measure as independent

variables. After completing each pair of multiple regressions, the results from Group 1 were compared with the results from Group 2. The independent variables identified as contributing to the multiple regression for both Group 1 and Group 2 were identified as significant results. By splitting the data into two equal parts and conducting the exact analyses on each group, the problem of artificially increasing the likelihood of finding significant results may be avoided. Only reliable predictors would be significant in both Group 1 and Group 2. This procedure was implemented for each of the multiple regressions utilized in the following analyses.

In order to examine the role of perceived therapeutic experience, three groups of multiple regressions were used. First, these extra analyses specifically addressed how the perceived experience of therapy was associated with the perceived effectiveness of therapy. Second, these additional procedures investigated how the perceived experience of therapy was related to preference of therapy. Finally, analyses examined how perceived experience of therapy was associated with expected outcomes of therapy for depression, a problem more severe than depression, and a problem less severe than depression.

Perceived experience and perceived effectiveness. The first analysis examined the connection between the perceived experience of therapy and perceived effectiveness. Two multiple regressions were conducted, one with Group 1 and one with Group 2. The results of these analyses may be found in Table 5. The multiple regression conducted with Group 1 produced an equation with significant results. R for regression was significantly different from zero, $F(3,53) = 36.456$, $p = .000$. Three factors were found to

Table 6. Perceived Experience Factors Associated with Perceived Effectiveness

Group 1	Group 2
Feeling Understood in Cognitive Therapy (Affective Experience #8)	Feeling Comfortable during Cognitive Therapy (Affective Experience #1)
Thinking Your Time was Productive in Solution-Focused Therapy (Cognitive Experience #6)	Being Able to Share Difficult Information with the Therapist In Solution Focused Therapy (Behavioral Experience #5)
Being Challenged by the Interaction in Cognitive Therapy (Cognitive Experience #5)	Being Able to Examine Yourself and your Current Problem Situation in Cognitive Therapy (Cognitive Experience #7)

Table 6 cont.

Group 1	Group 2
	Being Able to Examine Yourself and Your Current Problem Situation in Solution-Focused Therapy (Cognitive Experience #7)
Factors Common to Both Group 1 and Group 2	
None	

be significant contributors to this equation: "Feeling understood" in cognitive therapy, "Thinking your time was productive" in solution-focused therapy, and "Being challenged" by the interaction in cognitive therapy. The multiple regression for Group 2 also produced an equation with significant results. R for regression was significantly different from zero, $F(4,54) = 14.299$, $p = .000$. Four factors were found to be significant contributors to this equation: "Feeling comfortable" during cognitive therapy, "Being able to share difficult information" with the therapist in solution-focused therapy, "Being able

to examine yourself and your current problem situation" in cognitive therapy, "Being able to examine yourself and your current problem" in solution-focused therapy.

The results of the multiple regressions conducted to examine the connection between the perceived experience of therapy and perceived effectiveness produced separate significant results for Group 1 and for Group 2, but failed to identify any factors common to both. Therefore, no overall significant association between the perceived experience of therapy and perceived effectiveness was identified.

Perceived experience and preference. The next analysis examined the connection between perceived experience and preference of either cognitive therapy or solution-focused therapy. Two multiple regressions were conducted, one with Group 1 and one with Group 2. The results of these statistical analyses may be found in Table 7. The multiple regression conducted with Group 1 produced an equation with significant results. R for regression was significantly different from zero, $F(6, 50) = 22.857$, $p = .000$. Six factors were found to be significant contributors to the equation: "Feeling as if you were understood" in cognitive therapy, "Thinking that your time in therapy was productive" for solution-focused therapy, "Being able to remain physically comfortable" during cognitive therapy, "Feeling dependent" during cognitive therapy, "Feeling as if you were being controlled" during cognitive therapy, and "Being able to remain physically comfortable" during solution-focused therapy. The multiple regression for Group 2 also resulted in a significant outcome. R for regression was significantly different from zero, $F(3, 55) = 18.407$, $p = .000$. Three factors were found to be significant contributors to this equation: "Developing insight about your problem" for

Table 7. Perceived Experience Factors Associated with Preference

Group 1	Group 2
Feeling you were understood During Cognitive Therapy (Affective Experience #8)	Being able to Develop Insight About Your Problem in Cognitive Therapy (Cognitive Experience #2)
Thinking Your Time was Productive in Solution-Focused Therapy (Cognitive Experience #6)	Thinking Your Time was Productive in Solution-Focused Therapy (Cognitive Experience #6)
How much would you have been able to remain physically comfortable during Cognitive Therapy (Behavioral Experience #4)	Being able to Say What You Wanted during Cognitive Therapy (Behavioral Experience #1)

Table 7 cont.

Group 1	Group 2
Feeling dependent during Cognitive therapy (Affective Experience #6)	
Feeling you were being Controlled during Cognitive Therapy (Affective Experience #10)	
How much would you have been able to remain physically comfortable during Solution-Focused Therapy (Behavioral Experience #4)	
Factors Common to Both Group 1 and Group 2	
Thinking Your Time was Productive in Solution-Focused Therapy	

cognitive therapy, "Thinking your time in therapy was productive" for solution-focused therapy, and "Being able to say what you wanted" during therapy for cognitive therapy.

One independent variable, "Thinking that your time in therapy was productive" for solution-focused therapy, contributed significantly to the regression equations for both Group 1($sr_i^2 = -.210$) and Group 2 ($sr_i^2 = -.455$). For both groups, higher ratings of thinking that time in solution-focused therapy was productive were found to be associated with stronger preferences for solution-focused therapy. Even though there were six factors found to significantly contribute to the regression equation for Group 1 and three factors for Group 2, the preceding result is the only common, and therefore only significant, outcome. No other perceived experience ratings were found to be associated with preference for solution-focused or cognitive therapy for both split file groups.

Perceived experience and expected outcomes. Finally, a series of multiple regressions was conducted to explore the relationship between ratings for perceived experience and expected outcomes. Six pairs of multiple regressions were conducted using the split data. The expected outcomes for depression, a problem more severe than depression, and a problem less severe than depression were examined in relationship to the perceived experiences of both solution-focused therapy and cognitive therapy. Whereas each of the individual multiple regression produced significant results, comparison of each pair of multiple regressions found very few significant results common to both groups. Specifically, there were only two significant results. The multiple regressions examining the association between perceived experience of solution-focused therapy ratings and the expected outcomes for a problem less severe than depression found one common factor. "Feeling listened to" during solution-focused

therapy was identified as being associated with a problem less severe than depression. The more the participants felt as though they were being listened to during solution-focused therapy the more the participants believed that solution-focused therapy would be helpful for a problem less severe than depression. There were no significant results found for the perceived experiences of cognitive therapy and expected outcomes for a problem less severe than depression. The second significant result, "Feeling relieved," was found to be associated with the perceived experience of cognitive therapy and the expected outcomes for a problem more severe than depression. The more participants felt relieved during cognitive therapy the more they believed that cognitive therapy would be helpful for a problem more severe than depression. There were no significant associations between the perceived experience of solution-focused therapy and the expected outcome for a problem more severe than depression. Furthermore, there were no significant results between the perceived experience of solution-focused therapy or cognitive therapy and the expected outcome for a presenting problem of depression.

Participants with Previous Therapy Participation

The impact of individuals who had previous therapy experience was investigated. Of the 117 participants, 29 identified themselves as having previously participated in a form of therapy. These individuals ranged in age from 18 to 30 and the gender breakdown was 34.5% men and 65.5% women. This demographic information is very similar to the demographic information for the entire pool of participants. The types of helpers seen by these participants were as follows: 7 (24.1%) were seen by a psychologist, 7 (24.1%) were seen by a psychiatrist, 13 (44.8%) were seen by a counselor, 0 (0%) were

seen by clergy, 1 (3.4%) was seen by a peer, and 1 (3.4%) identified being seen by an "other." Only 4 of the 29 identified their past therapeutic experience as negative.

All of the statistics previously described to examine the study hypotheses and the additional analyses, including the split-file method described by Stevens (2001), were repeated with the 29 individuals removed who identified a previous therapy experience. No significant changes were found for the results of the analyses to assess the perception of the therapy videos. There were also no changes in the results addressing the study hypotheses. Additionally, the results for these additional analyses examining how perceived experience was associated with perceived effectiveness and preference were unchanged.

The comparison of experience ratings produced one changed result after removing the 29 individuals who identified a previous therapy experience. Of the 19 statistically significant results formerly detailed with the entire sample of participants, 18 of them remained statistically significant. Specifically, the behavioral experience measure "How much would you have been able to listen during therapy" ($p = .011$) was found to not meet the threshold of significance previously identified for this series of statistical analyses ($p < .002$).

The additional analyses that examined the relationship between perceived experience and expected outcomes produced changed results after removing the 29 participants who identified a previous therapy experience. With this partial sample, many more associations were uncovered than during the initial series of multiple regressions. Originally with the entire sample of participants, two associations were identified: "Feeling listened to" was associated with the ability of solution-focused therapy to help

Table 8. Perceived Experience Factors Associated with Expected Outcomes (Full Sample)

Therapy and Problem Situation	Experience Factors
Solution-Focused Therapy	
Depression	None
Problem More Severe than Depression	None
Problem Less Severe than Depression	"Feeling Listened to"
Cognitive	
Depression	None
Problem More Severe than Depression	"Feeling Relieved"
Problem Less Severe than Depression	None

for a problem less severe than depression and "Feeling relieved" was associated with the ability of cognitive-therapy to help for a problem more severe than depression. After removing the 29 participants who identified a previous therapy experience, "Feeling relieved" was still associated with a belief that cognitive therapy would be helpful for a problem more severe than depression. However, unlike the results from the full sample, "Feeling listened to" was not found to still be associated with a belief that solution-focused therapy would be helpful for a problem less severe than depression. Nevertheless, five additional associations were identified after removing participants with a history of therapy experience. Each of these associations was inconsistent with the

original results from the multiple regressions utilizing the full sample. Tables 8 and 9 provide information about the relationship between perceived experience and expected outcomes for both the full sample and the sample without participants who identified a previous therapy experience.

Table 9. Perceived Experience Factors Associated with Expected Outcomes (Partial Sample – Without Participants Who Identified Previous Therapy Experience)

Therapy and Problem Situation	Experience Factors
Solution-Focused Therapy	
Depression	"Think That Your Time In Therapy Was Productive"
Problem More Severe than Depression	"Think That Your Time In Therapy Was Productive"
Problem Less Severe than Depression	"Remain Physically Comfortable"
Cognitive	
Depression	"Feeling Relieved"
Problem More Severe than Depression	"Feeling Relieved"*
Problem Less Severe than Depression	"Examine Yourself and Your Current Problem Situation"

Note. Asterisk indicates that the experience factor was also identified in a full sample of participants, including participants who identified a previous therapy experience.

CHAPTER IV

DISCUSSION

The purpose of this study was to explore the connections between personality and perceived experiences of solution-focused therapy and cognitive therapy. Specifically, the role of personality factors was examined as related to preference for either form of therapy. Information was also obtained about the overall preference for and perceived effectiveness of each form of therapy. Furthermore, this study also utilized additional analyses to investigate the perceived experience of each form of therapy and how it relates to perceived effectiveness, preference, and expected outcomes.

When interpreting the results of this study, the methodology should be taken into account. The participants in this study were not actual clients but individuals asked to vicariously imagine their involvement in two different forms of therapy. Additionally, the therapy videos only represented a portion of one session of each form of therapy. Despite these potential limitations, this study does provide some insights about therapeutic experience.

Perception of Therapy Videos

This study was conducted under the assumption that the therapy vignettes accurately represented the therapy depicted in them. Each of the videos was created from published materials designed to teach how to conduct that specific form of therapy.

Furthermore, individuals with the expertise in each form of therapy evaluated the accuracy of the vignettes. Therefore, regardless of what the participants indicated that they observed, each of the videos possessed a strong foundation in their respective form of therapy.

This assumption of accurate representation of both forms of therapy was empirically examined and, initially, was determined to be only partially true. The cognitive therapy video was found to be consistent with cognitive therapy techniques. Nevertheless, there was some question as to whether the solution-focused therapy video accurately represented solution-focused therapy. It was believed that the solution-focused therapy video would have higher ratings on the solution-focused therapy dimension than the cognitive video. This was not found to be true. As the solution-focused therapy video was adapted directly from an actual solution-focused therapy transcript, it seems likely that there may be other factors that were behind this unexpected result.

The three items representing solution-focused therapy on the Therapeutic Technique measure were not originally designed to measure solution-focused characteristics. Two of the three items were originally designed to address humanistic techniques. One of the items was not part of the original scale designed by Dancey et al. (1992) and did not go through the original creation process. These items, although face valid, may have not accurately measured the solution-focused characteristics of each video. Thus, if the items were not actually measuring solution-focused characteristics, the results would not have meant that the cognitive therapy video possessed more

characteristics consistent with solution-focused therapy than the solution-focused therapy video.

One theoretical explanation for the lower solution-focused ratings for the solution-focused therapy video may be found through comparison of the therapeutic technique ratings. The therapeutic technique ratings for the cognitive therapy video were higher on all four subscales than the same ratings for the solution-focused therapy video. The emphasis in solution-focused therapy on a subjective, personal reality may inadvertently create the impression that the therapist is not playing an active role in the therapy session – thus producing lower ratings on all therapeutic technique measures.

Another potential explanation for the cognitive therapy video being rated as having more solution-focused characteristics than the solution-focused video relates to the nature of the solution-focused intervention. Specifically, the components of the solution-focused intervention may be harder to observe than the method of intervention in cognitive therapy. Solution-focused therapy utilizes an equal relationship between the client and the therapist whereas cognitive therapy is conducted in an authoritative manner. Such an equality may have masked the therapeutic components for the participants observing the therapeutic interactions. Specifically, the participants may have not recognized how the solution-focused therapist was conducting therapy.

Even though the solution-focused ratings were lower for the solution-focused therapy video than the cognitive therapy video, other results support the accuracy of the solution-focused therapy video. Upon examination of the therapeutic technique ratings for the solution-focused video, the solution-focused ratings were the highest and therefore best descriptor of the four forms of therapy being examined. The statistical analyses

determined that the solution-focused therapy ratings were statistically higher than ratings for cognitive therapy and a common sense approach to therapy. The results also indicated that solution-focused therapy was not found to be significantly different from a psychoanalytic approach.

This outcome may indicate that the solution-focused therapy video did not accurately represent solution-focused therapy. However, an alternative approach to understanding this result involves examining the items used to evaluate the psychoanalytic approach. The psychoanalytic item that received the highest rating for the solution-focused video was item 10. This item asked "...to what extent did the therapist help you by showing you how things from your past are playing an important part in your problems now." In the absence of context, such a statement may be commonly viewed as a psychoanalytic approach. However, such a statement may also be highly consistent with a solution-focused approach to therapy. In solution-focused therapy, the therapist helps the client to identify and mobilize the resources that are already in existence to deal more effectively with a current problem. A strong emphasis is placed on activities that have already been tried and how they affected the current problem. The participants in this study may have recognized the overlap of this factor with solution-focused therapy and rated accordingly on item 10. Thus, solution-focused therapy ideas are consistent with this one item that was intended to measure the psychoanalytic approach. This conceptual overlap may have artificially elevated the ratings for the psychoanalytic therapeutic technique assessment.

Overall, it can be concluded that both forms of therapy were accurately represented in their respective videos. This is supported both by opinions of experts and, to a somewhat lesser extent, by observations of the research participants.

Comparison of Perceived Therapeutic Experience

Inspection of the results for the experience measures unveils overwhelmingly positive ratings for cognitive therapy. Of the 23 analyses, 19 produced significant results – all of which supported the more positive experience of cognitive therapy compared to solution-focused therapy. These significant results included positive affective, cognitive, and behavioral experiences. Clearly the perceived experience of cognitive therapy was substantially better than the perceived experience of solution-focused therapy.

There are numerous ways to interpret these results. The simplest interpretation suggests that the participants experience ratings were not influenced by preconceived ideas or beliefs about therapy. According to this explanation for the overwhelmingly positive experience ratings for cognitive therapy, the participants simply liked cognitive therapy better than solution-focused therapy.

Another possible explanation for the overwhelmingly positive experience ratings for cognitive therapy pertains to the prevalence of deficit-based interventions. If deficit-based interventions are viewed as the most common form of therapy, it would be likely that similar experiences would be identified as more positive than a different therapy that is inconsistent with such approach. For example, participants may be more likely to identify high ratings for the experiences such as "Feeling eager to continue," "Thinking that time in therapy was productive," and "Remaining physically comfortable" for a form of intervention that is viewed as common as opposed to a less common one. Specifically,

there are many factors associated with cognitive therapy that the participants may have judged to be common with their beliefs about deficit-based forms of intervention. An authoritative therapist may have been one of these factors. By assuming a dominant role within the therapy session through setting an agenda and challenging thoughts of the client, the cognitive therapy vignette may have been highly consistent with the currently prevalent deficit-based approach. These actions are not present in solution-focused therapy and it may have been judged to be inconsistent with the most common form of therapy currently present.

Even though solution-focused therapy was not rated in as positive of a manner as cognitive therapy, these results do not mean that it was viewed as aversive. The statistical procedures used in this study directly compared the experience of solution-focused therapy to the experience of cognitive therapy. Therefore, the results only indicate that solution-focused therapy was rated in a less positive manner than cognitive therapy. They do not provide information about how the experience of solution-focused therapy may compare to the experience of other forms of therapy.

Exploration of Hypotheses

Hypothesis 1 and 2: Personality and preference. The primary purpose of this study was to examine how personality variables are related to preference for cognitive or solution-focused therapy. The first hypothesis proposed that individuals with high scores on the dependent and compulsive scales of the MCMI-II would report a preference for cognitive therapy. The second hypothesis claimed that individuals with high scores on the histrionic and narcissistic scales would identify a preference for solution-focused therapy. Neither of these hypotheses was supported. There are many possible

explanations as to the absence of connection between these four personality variables and preference for type for therapy.

One possible explanation for these results concerns the perceptions of the participants. Perhaps the differences between cognitive therapy and solution-focused therapy were not evident to a non-expert observer. Solution-focused therapy and cognitive therapy differ in their focus, style, and interventions. Nevertheless, observers without information about these forms of therapy may not be able to perceive such differences in each video. Manthei (1988) suggested that clients are unable to identify specific characteristics of therapy. The results of the ratings indicate that the participants were able to identify a difference between the two therapies represented in the two videos; however, as discussed earlier, it is not clearly evident if this difference is consistent with the theoretical differences between these two forms of therapy. Thus, some differences between solution-focused therapy and cognitive therapy may be apparent enough to be noted but the actual theoretical differences between each form of therapy may be subtle enough that they are not observed.

The lack of support for the hypothesized associations is consistent with some previous research. Heaven and Furnham (1994) found only limited support for the connection between personality and preference for type of psychological treatment. Specifically, this study concluded that individuals high on extroversion and neuroticism personality traits were more likely to prefer cognitive and behavioral therapies; however, many other personality traits were also examined without uncovering significant associations with therapy preference. Further, Hollander-Goldfein, Fosshage, and Bahr

(1989) did not find any personality variables to be significantly associated with preference of therapist. The results reported here are consistent with these prior studies.

Even though the hypotheses related to the previously identified personality variables and preference for either cognitive therapy or solution-focused therapy was not supported, the analysis did identify one unexpected association. The schizoid personality dimension was found to be significantly associated, albeit minimally, with a preference for solution-focused therapy.

There was no prediction that the schizoid personality dimension would be associated with a preference for either form of therapy. One possible reason that individuals with relatively high schizoid personality characteristics rated solution-focused therapy as more preferable is related to a desire for individuality common to schizoid personality (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2000). Such an attitude is more consistent with solution-focused therapy than cognitive therapy. In solution-focused therapy, clients have much autonomy to present their issues and conduct the session as they please. The solution-focused therapist participates on an equal level to facilitate the development of a resolution. The client in cognitive therapy is not as free to express his/her individuality and unique ways of personal expression. Therefore, individuals with high scores on the schizoid dimension may prefer solution-focused therapy due to its greater focus on individuality.

Another possible explanation for the connection between high scores on the schizoid dimension and the preference for solution-focused therapy relates to how such individuals respond to others. Individuals who display characteristics associated with schizoid personality may express indifference to praise or criticism from others (DSM-

IV-TR, 2000). Such a reaction may cause a client to connect poorly with a therapist in cognitive therapy. It would appear likely that such individuals would not be invested in the direct confrontation offered by a cognitive therapist. This lack of investment may motivate individuals high on the schizoid dimension to discontinue cognitive therapy because the direct statements designed to correct specific cognitive deficits are received as more benign than helpful. Solution-focused therapy on the other had offers such individuals a very different way to experience therapy. Specifically, the solution-focused therapist employs direct praise and criticism to a much lesser extent than the cognitive therapist. The therapeutic relationship and emphasis on personal input within solution-focused therapy may be more appealing to individuals with high ratings of schizoid personality than a more directive and confrontive approach consistent with cognitive therapy.

Despite the potential explanations for the outcome of this finding suggesting a relationship between schizoid personality and a preference for solution-focused therapy, it must be examined within a larger context. This result only describes about 4% of the variance. Therefore, 96% of the variance in therapy preference remains unexplained by personality factors. Schizoid personality characteristics may be the only personality factor that relates significantly to therapeutic preference, but there remains one or more other factors that describe a larger, more substantial portion of the variance for preference of therapy.

The results of these analyses suggest that personality does not seem to matter in determining preference for either cognitive or solution-focused therapy. This lack of an association is not derived from the absence of an identified preference, as the participants

in this study clearly identified a preference for cognitive therapy. Therefore, factors other than MCMI-II personality dimensions appear to be more imperative in the identification of preference between cognitive therapy and solution-focused therapy. Perhaps personality dimensions other than those identified by the MCMI-II may be more helpful in describing therapy preference; however, the results of these analyses suggest that personality may only be an extremely minor factor when determining preference between cognitive therapy and solution-focused therapy.

Hypothesis 3: Perceived effectiveness. The third hypothesis in this study directly addressed perceptions of effectiveness. It was hypothesized that participants in this study would perceive cognitive therapy to be more effective than solution-focused therapy. This hypothesis was confirmed.

It was believed that deficit-based forms of intervention are so prevalent in the mass media that the participant's view of therapy as a whole has been influenced. Cognitive therapy, a deficit-based intervention, may be consistent with the image that individuals carry with them about what therapy is all about. For individuals with no expertise in a certain area, it is only natural to infer that if something is the most common, it must be the best. If individuals believe that cognitive therapy is most like what is commonly identified as therapy, it is likely that it is believed to be the most effective form.

Another potential explanation for the outcome indicating that cognitive therapy was rated as more effective than solution-focused therapy is that solution-focused therapy may have been viewed as a less formal and more conversational form of intervention. Perhaps this informal nature allowed participants to associate such solution-focused

interactions with other informal helping situations such as those generally received from friends and family members. This less formal approach to helping is likely viewed as less effective.

Finally, the examination of perceived experience for each of the therapies in this study may also provide some information about judgments of perceived effectiveness. The perceived experience of cognitive therapy was found to be more favorable than the perceived experience of solution-focused therapy. This difference was present for emotional, cognitive, and behavioral experiences. These differences in experience may have been a factor that supported the perception that cognitive therapy was more effective than solution-focused therapy. If participating in one form of therapy, cognitive therapy, is viewed as a positive experience, it is likely that it may also be rated as highly effective. Concurrently, if the experience of another form of therapy, solution-focused therapy, is not viewed as positively, it is very unlikely that it would be perceived to be as effective.

Hypothesis 4: Overall preference. The final hypothesis in this study addressed overall preference for either cognitive therapy or solution-focused therapy. It was hypothesized that due to the conversational nature and an emphasis on optimism, solution-focused therapy would be identified as being a more preferable method of therapy than cognitive therapy. This hypothesis was not confirmed as cognitive therapy was found be significantly more preferable than solution-focused therapy.

Even though this outcome was contrary to what was hypothesized, it is highly consistent with the results from Dancey et al. (1992). Within their study, Dancey et al. (1992) determined that when participants were asked about their involvement in a hypothetical therapy situation, they chose a cognitive-behavioral approach over a

humanistic approach and two others. Furthermore, the outcome of the study presented here is also consistent with a study by Cashen (1979). In that study, it was found that a non-clinical group of participants chose behavioral forms of intervention over more client-centered forms of intervention. The results of both studies are consistent with the preference of a deficit-based intervention over a competence-based intervention as was found in this study.

One potential explanation for this outcome is the connection to effectiveness. Participants were asked to assume equal effectiveness for both forms of therapy when rating preference. However, statistical analysis suggests that there is a strong correlation between the participant ratings for effectiveness and preference. Results of this correlation suggest that the items assessing effectiveness and preference may have actually been measuring the same construct. Individuals may have been unable to eliminate effectiveness as a factor when deciding preference. If participants were unable to separate preference from effectiveness, they would likely prefer the therapy perceived as being more effective. Further credence is given to this explanation through inspection of the measure assessing effectiveness and preference. The order of the items on this measure asked about effectiveness first and then asked about preference. Therefore, all participants were inadvertently presented with the idea of effectiveness immediately prior to providing ratings of preference. This could have easily influenced their ratings of preference. As individuals perceived cognitive therapy to be more effective than solution-focused therapy, they may have used this information to also find cognitive therapy as more preferable – explaining the result that is contrary to the original hypothesis.

Another possible explanation for the preference for cognitive therapy is that solution-focused therapy may have appeared to have too much of an emphasis on personal characteristics. It was believed that participants would view the focus on the client's subjective reality as a positive factor. It was also believed that participants would view the client's share of leadership in the session as a positive factor. Perhaps the participants did not view such an emphasis on personal dimensions as a positive factor but rather as a negative one. They may have believed that solution-focused therapy placed too much pressure on individuals to take responsibility for their improvement. Rather than viewing such interactions as empowering, participants may have viewed such interactions as the therapist taking little or no responsibility in therapy. This explanation purports that participants may not be looking to play an active role in their treatment but merely looking to find another individual that can help them to resolve their issues. Such individuals may desire the structure of a deficit-based intervention where the therapist can "fix" their problem. In this manner, the deficit-approach, not just cognitive therapy is preferred.

A final possible explanation of the preference for cognitive therapy relates to the participants' preconceived ideas about therapy. Based upon the preponderance of deficit-based interventions in society, cognitive therapy may appear to be more consistent with how the participants in this study view "therapy." Beliefs about preference may be impacted by these preconceived ideas. The more a given therapy is consistent with the participant's beliefs about what "therapy" should be, the more this individual is likely to prefer that method of psychological intervention. Therefore, since cognitive therapy is more consistent with the ideas of deficit-based interventions than solution-focused

therapy, cognitive therapy is identified as the preferred form of intervention over solution-focused therapy.

Additional Analyses

The statistics that comprised the additional analyses utilized multiple variables in an exploratory attempt to uncover preliminary information about the role of perceived experience in therapy. Many of these analyses revealed no or few statistically significant associations.

The scarcity of significant factors for the multiple regression analyses, specifically those addressing effectiveness and preference, is contrary to what might be expected. Specifically, the strong perceived effectiveness of and preference for cognitive therapy examined in conjunction with the highly positive ratings for the experience of cognitive therapy would suggest many significant associations. Nevertheless, very few significant results were found in the multiple regression analyses.

There are many potential explanations for the lack of significant findings for these additional analyses. The statistical limitations associated with these analyses may have reduced the chances of uncovering less than robust results. According to the split-file procedure identified by Stevens (2001) used in this study, robust results should be clearly evident. Nevertheless, such a procedure diminishes statistical power by reducing sample size and may mask other associations that are not as strong. The statistical procedures utilized to effectively handle the excess of independent variables in this study may have hidden associations otherwise apparent through the use of other statistical means.

An additional potential explanation for the lack of results obtained from these additional analyses concerns the independence of the experience items. The 23 different experience items were significantly intercorrelated. The intercorrelations of the experience ratings were computed. For the cognitive video they ranged from .21 to .76 and the correlations for the solution-focused video ranged from .30 to .73. Therefore, the series of paired t-tests used to evaluate experience were not independent and may have simply revealed that the participants in this study "liked" cognitive therapy better than solution-focused therapy. Each of the 23 experience dimensions may have measured the same construct.

Further, another explanation for the lack of significant findings may concern the different statistical procedures used in this study. In order to examine the perceived experience of each form of therapy, paired t-tests were utilized. These analyses directly compare two variables. Specifically, they were used to determine if the means of two different groups were statistically different. For the additional analyses in this study, multiple regressions were the primary statistical procedures. The multiple regressions utilized in this study were conducted using a stepwise method. The variables entered into the regression equation, those found to be significantly associated with the criterion, were only included if they accounted for a unique portion of the variance. But, as described above, the 23 experience variables were strongly intercorrelated and the t-tests did not examine variance unique to each variable. The mathematical foundations of the multiple regressions and t-tests are very different. Thus, contrast between the t-test findings and the multiple regression findings may be accounted for by these differences.

Another potential hindrance for these additional analyses that may have contributed to the lack of significant findings relates to the expectations of the participants. Individuals participating in this study were asked to imagine themselves as the client in the therapy videos. From this mental exercise, questions were asked to determine how the participants perceived such experiences. If the participants were unable to mentally place themselves within the video presentations, they would not be able to provide accurate information about perceived experience. Therefore, if the participants were unable to mentally place themselves in the therapy videos as the client, the validity of the information they provided about experience would be questionable. There would not have been any associations between perceived experience and any other variable because perceived experience would have been a statistical artifact. If this explanation were true, one might expect that there would have been no difference between the measures of therapeutic experience. Thus, this explanation seems rather unlikely. Nevertheless, the ability of the participants to place themselves within the vignette was not assessed, and therefore cannot be evaluated.

Finally, the limited information obtained through the multiple regression analyses of experience may highlight the individuality of therapeutic involvement. Unique individual differences may play a role in dictating therapeutic experience. Such individual factors of each participant may go beyond generalizable dimensions that are able to be examined in a quantitative manner. Perhaps the best way to examine concepts such as therapeutic experience may be through qualitative means, as suggested by Etchison and Kleist (2000), where unique personal dimensions may be identified and recognized.

Despite the preceding factors, some information was generated through the additional analyses exploring perceived experience. Specifically, these procedures produced findings about how perceived experience is related to preference, perceived effectiveness, and expected outcomes.

Perceived experience and perceived effectiveness. Through the additional analyses, the relationship between the perceived experience of both forms of therapy and perceived effectiveness was examined. No experience factors were found to be associated with perceived effectiveness. Thus factors other than what was assessed in this study may influence which form of therapy is perceived as more effective.

The attitude about deficit-based interventions is a factor that may be more related to effectiveness than perceived experience. In this study, cognitive therapy, a deficit-based therapy, was rated by participants to be more effective than solution-focused therapy. This may have occurred because images and ideas consistent with deficit-based interventions are commonly portrayed within the mass media. Cognitive therapy as portrayed in the therapy video may have much in common with the deficit-based therapies portrayed within society. These commonalities may have been a factor when participants identified which therapy was perceived as more effective. Assuming the cognitive therapy vignette is similar to the deficit-based therapies portrayed in society, the actual experience of therapy would provide only a negligible amount of influence when deciding which therapy is most effective. Therefore, cognitive therapy may have been rated as being effective due to its similarities to prominent deficit-based interventions portrayed within society rather than because of the perceived experience of it.

Perceived experience and preference. The next area investigated with these additional analyses was how the experience of therapy was associated with preference. It was found that "Feeling that your time was productive" in solution-focused therapy was associated with a preference for solution-focused therapy. Such results indicate that if participants saw that things were being accomplished in solution-focused therapy they would express a stronger desire to participate in it as compared to cognitive therapy. As no other emotions, thoughts, or behaviors were found to be significantly associated, it appears that the participants did not assess preference by the mechanics or activities of solution-focused therapy but by its outcome.

Perhaps the prevalence of deficit-based therapies impacted this result. The overwhelming presence of deficit-based interventions may have created a negative image for solution-focused therapy. Due to the conversational nature, participants may see solution-focused therapy as a less focused and less formal style of therapy than deficit-based approaches. Even though this form of therapy may be viewed in a negative manner, participants may be willing to participate in it with assurances of productivity. Participants may express a belief that if this less common and more conversational form of therapy is productive, they may be willing to participate in it. Thus, despite the differences between solution-focused therapy and deficit-based interventions, participants would be willing to become involved in this different type of intervention if it were believed to be productive.

Perceived experience and expected outcomes. The final component of the additional analyses examined the relationship between perceived experience and expected outcomes. There were two significant results uncovered in this analysis. For solution-

focused therapy, "Feeling you were listened to" was found to be associated with an ability to help for a problem less severe than depression; and for cognitive therapy, "Feeling relieved" was found to be associated with an ability to help for a problem more severe than depression.

Thus being listened to was an important component of solution-focused therapy, for lesser psychological difficulties. This suggests how participants perceived the experience of solution-focused therapy. It supports the emphasis of the cooperative nature as a helpful component to solution-focused therapy. In order to be "listened to" there needs to be another individual willing to actively receive the information. For a problem less severe than depression, the feeling of being listened to was viewed as a means to improvement.

It was also determined that the more participants felt relieved during cognitive therapy, the more that form of therapy was believed to help for a problem more severe than depression. This suggests how participants perceived the experience of cognitive therapy. Unlike the previously identified results describing the emphasis on the cooperative nature of solution-focused therapy, the results associated with cognitive therapy provide little information about the therapeutic relationship between client and therapist. What is emphasized through these results is symptom relief. Specifically, "Feeling relieved" was the identified factor that predicted successful outcomes for cognitive therapy with a problem more severe than depression. This suggests that progression toward symptom relief may be the primary factor in determining whether or not cognitive therapy is perceived to be a helpful intervention for a problem more severe than depression.

Future Directions

The methodological limitations of this study offer suggestions for future research. One concern relates to the presentation of the therapeutic interactions. Participants were third-party observers asked to view a video of actors portraying individuals within the therapeutic relationship. The videos each only represented a portion of one therapy session. Obtaining information from participants viewing such therapy rather than participating in it may have influenced the outcomes. Future studies should utilize real clients involved in therapy in order to minimize difficulties associated with participants having to vicariously place themselves within a presented scenario. Even though utilizing actual clients would reduce problems associated with the presentation of the therapies, such a study would be difficult to carry out due to variables associated with different presenting problems of the clients, multiple therapists, and maintaining the integrity of each form of therapy.

Another limitation of this study concerns the statistical use of experience dimensions with this relatively large sample. In this study, there were statistical limitations that prevented all 23 experience dimensions to be statistically examined at the same time with this sample. Future studies may want to consolidate the measures of experience or increase the size of the sample to eliminate such problems. This alteration of the experience variables would eliminate many of the statistical constrictions involved in the study presented here. Future studies should also implement a better way to assess the experience of each form of therapy. Perhaps qualitative descriptions or psychophysiological methods may be used to best assess the experience of each form of therapy. Qualitative measures of therapy experience, as suggested by Etchison and Kleist

(2000), may allow for a more descriptive and accurate measurement of experience. Further, psychophysiological methods may provide an understanding of how specific events within the therapy process immediately affect the participant.

This study utilized a sample of individuals with a uniform age and educational experience. It also examined the differences between only two forms of therapy, cognitive therapy and solution-focused therapy. Future studies may replicate this study with the inclusion of other subgroups of the population and other forms of therapy. Further, many of the potential explanations for the results of this study discussed the role of client expectations. Future research should continue to examine how such expectations may relate to evaluations of the therapeutic process and successful outcomes. A related area of future research may investigate the consistency between a client's belief about what "therapy" should be and the actual therapy experience. Finally, the additional analyses section of this study produced preliminary information about the experience of therapy. Future studies may attempt to expand on the information identified here. Specifically, further researchers may want to examine the experience of therapy for different presenting problems in order to better understand the role of perceived experience in therapy.

Appendix A
Therapeutic Techniques

Therapeutic Techniques

Imagine that you were the client in the vignette, to what extent did the therapist help you by...

1) Utilizing your individual and unique abilities to help you handle your problem
Not at all___-___-___-___-___-___-___-___To a great extent

2) Offering you reassurance
Not at all___-___-___-___-___-___-___-___To a great extent

3) Teaching you new coping and problem-solving skills
Not at all___-___-___-___-___-___-___-___To a great extent

4) Showing you how your problems are mirrored in your relationships with your counselor
Not at all___-___-___-___-___-___-___-___To a great extent

5) Teaching you to change your behavior
Not at all___-___-___-___-___-___-___-___To a great extent

6) Teaching you not to dwell on your problems
Not at all___-___-___-___-___-___-___-___To a great extent

7) Making you feel on an equal level in the relationship
Not at all___-___-___-___-___-___-___-___To a great extent

8) Interpreting the meaning behind your symptoms
Not at all___-___-___-___-___-___-___-___To a great extent

9) Respecting above all your way of viewing the world
Not at all___-___-___-___-___-___-___-___To a great extent

10) Showing you how things from your past are playing an important part in your problems now
Not at all___-___-___-___-___-___-___-___To a great extent

Appendix A
Therapeutic Techniques

11) Giving you advice
Not at all___-___-___-___-___-___-___To a great extent

12) Teaching you to identify and change dysfunctional attitudes
Not at all___-___-___-___-___-___-___To a great extent

Appendix B
Expected Outcomes

Expected Outcome

Imagine that you were the client in the video. With that context in mind,...

1) How much do you think that this type of therapy would be helpful for depression?
Very Much___-___-___-___-___-___-___Not At All

2) How much do you think this type of therapy would be helpful to you for a different problem MORE severe than depression?
Very Much___-___-___-___-___-___-___Not At All

3) How much do you think this type of therapy would be helpful to you for a different problem LESS severe than depression?
Very Much___-___-___-___-___-___-___Not At All

Appendix C
Experience

Experience

Imagine that you were the client in the video. With that context in mind, how much would the experience of therapy make you feel...

1) ...comfortable during this therapy?
Very Much___-___-___-___-___-___-___None At All

2) ...frustrated during this therapy?
Very Much___-___-___-___-___-___-___None At All

3) ...stressed during this therapy?
Very Much___-___-___-___-___-___-___None At All

4) ...relieved during this therapy?
Very Much___-___-___-___-___-___-___None At All

5) ...defensive during this therapy?
Very Much___-___-___-___-___-___-___Not At All

6) ...dependent during this therapy?
Very Much___-___-___-___-___-___-___Not At All

7) ...you were listened to during this therapy?
Very Much___-___-___-___-___-___-___Not At All

8) ...you were understood during this therapy?
Very Much___-___-___-___-___-___-___Not At All

9) ...eager to continue during this therapy?
Very Much___-___-___-___-___-___-___Not At All

10) ...you were being controlled during this therapy?
Very Much___-___-___-___-___-___-___Not At All

11) ...your ideas were validated during this therapy?
Very Much___-___-___-___-___-___-___Not At All

Appendix C
Experience
cont.

Imagine that you were the client in the video. With that context in mind, how much would the experience of therapy help you...

1) ...think of your problem in a new way.
Very Much___-___-___-___-___-___-___Not At All

2) ...develop insight about your problem.
Very Much___-___-___-___-___-___-___Not At All

3) ...learn more about your own abilities
Very Much___-___-___-___-___-___-___Not At All

4) ...to be able to identify and conceptualize your problem.
Very Much___-___-___-___-___-___-___Not At All

5) ...to be challenged by the interaction in therapy.
Very Much___-___-___-___-___-___-___Not At All

6) ...think that your time in therapy was productive.
Very Much___-___-___-___-___-___-___Not At All

7) ... examine yourself and your current problem situation?
Very Much___-___-___-___-___-___-___Not At All

Imagine that you were the client in the video. With that context in mind...

1) How much would you have been able to say what you wanted during therapy?
Very Much___-___-___-___-___-___-___Not At All

2) How much would you have been able to listen during therapy?
Very Much___-___-___-___-___-___-___Not At All

3) How much would you have been able to maintain eye contact?
Very Much___-___-___-___-___-___-___Not At All

Appendix C
Experience
cont.

4) How much would you have been able to remain physically comfortable?
Very Much___-___-___-___-___-___-___Not At All

5) How much would you have been able to share difficult information with the therapist?
Very Much___-___-___-___-___-___-___Not At All

Appendix D
Demographic Information Questionnaire

Demographic Information Questionnaire

Please answer each of the items to the best of your ability:

1) What is your age? _____

2) What is your gender? Male Female

3) How many years have you attended UND? _____

4) Have you ever participated in any form of therapy? Yes No
If yes...

What type of helper worked with you? (circle one)

Psychologist Psychiatrist Counselor Clergy Peer Other

Over how long of a period did this therapy occur? _____

Which one of the therapy videos was most like what you experienced?

Video 1_____ Video 2_____ Neither_____

How would you characterize your previous experience

Positive_____ Negative_____

Appendix E
Preference Measure

Preference Measure

Please respond to each item by placing an X on one of the given blanks.

1) Which video showed a type of therapy that you think would be most effective in reducing problems related to depression?

Video 1 _____-_____-_____-_____-_____-_____-_____ Video 2
Most Effective Equally Effective Most Effective

2) Assuming that each method would be equally effective, which video showed a type of therapy that you would most like to participate in?

Video 1 _____-_____-_____-_____-_____-_____-_____ Video 2
Most Desirable Equally Desirable Most Desirable

Appendix F
Solution-Focused Therapy Video Script

Solution-Focused Therapy Video

Case Study From Berg and DeJong (1996)

Background Information

-19 year old

-Mother of 2 children (ages 3 and 4)

-Children removed from home by social services

-Referred to therapy by social services

-Currently feeling "depressed and stressed out"

Structure of the Session

1) Getting Started

2) Co-Constructing a Sense of Competence

3) Co-Constructing a Sense of What the Client Wants

4) Scaling: Measuring Client Constructions of Competence

Appendix F
Solution-Focused Therapy Video Script
cont.

Getting Started

Therapist: O.k., what can I do that would be helpful for you?

Patient: Well, I've been depressed and stressed out.

Therapist: Yeah I can imagine.

Patient: I just needed someone to talk to.

Therapist: I can imagine. Is that related to your children not living with you...to your stress and being depressed?

Patient: Yes.

Therapist: Or is there something else?

Patient: Well, the main reason is, 'cause my kids are not with me.

Therapist: I also understand that you were living with your children's father.

Patient: No.

Therapist: Some other person?

Patient: Uh huh.

Therapist: I understand he has been very abusive to you.

Patient: Yes.

Therapist: Is that what happened with the children?

Patient: Yes, not exactly.

Therapist: Not exactly. That was a separate thing - between you and him?

Patient: Right.

Co-Constructing a Sense of Competence

Therapist: And did I hear you correctly that you got out of that relationship?

Appendix F
Solution-Focused Therapy Video Script
cont.

Patient: Yes, I did.

Therapist: Wow! I wonder how you did that.

Patient: It was hard to do but...

Therapist: I'm sure it wasn't easy.

Patient: No, it wasn't.

Therapist: So how did you do it?

Patient: I just stayed away.

Therapist: You just stayed away from him? That's all?

Patient: Uh Huh.

Therapist: He didn't want to end the relationship?

Patient: No, and I got a restraining order put on him.

Therapist: You did? Was it helpful?

Patient: For a while it was, but he just kept coming back.

Therapist: So, he didn't want to break up?

Patient: Right.

Therapist: But you knew this was best for you?

Patient: Right.

Therapist: So... he didn't want to break up?

Patient: Right.

Therapist: But you knew this was best for you?

Patient: Right.

Therapist: So... he didn't want to, he kept coming back, how does he make this happen?

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cont.

Patient: Well, he was threatening me, threatening to kill me and...

Therapist: Wow.

Patient: And every time he sees me he jumped on me.

Therapist: He jumped on you, right. Even after you broke up?

Patient: Right.

Therapist: So that's when most women sort of become weak and they take him back. How come you didn't?

Patient: A couple of times I did because I was scared. And the more I kept going back to him, it

got worse and worse. And then he ended up hurting my son.

Therapist: Oh! Is that what did it?

Patient: That's what caused me to get my kids taken.

Therapist: Right, I see. So your children have been taken away because of what happened with him.

Patient: Right.

Therapist: So... was that helpful to break up with him or was it not helpful to break up with him?

Patient: Yeah, it was helpful. Because I feel that another man doesn't have the right putting his hand on someone else's child.

Therapist: Right.

Patient: And that child, you know, I feel that if that child didn't do anything to him, he has no business putting his hand on him.

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cont.

Therapist: Wow. You are very clear about that.

Patient: Yes. He broke my baby's leg!

Therapist: Uh huh. Right. But some women, even though he did that, some women would either get scared of him or, you know, somehow think that he's gonna change and take him back.

Patient: No. My kids come first.

Therapist: For you?

Patient: Right...my kids come first.

Therapist: Really?

Patient: And I shouldn't have to keep taking that abuse. And my kids don't have to take it.

Therapist: How did you know this? That your kids "didn't have to take it" and you shouldn't "have to take it?" How did you know this?

Patient: Because if I had stayed with him it would have ended up worse than what it was. Either me or my kids would have been somewhere dead or...

Therapist: Wow.

Patient: It wasn't worth it.

Therapist: Really? So, I mean, you knew it, you were very clear about this - that this is not worth it? No man is worth it.

Patient: Right, it wasn't. You know it wasn't worth it - beat up, walking around with black eyes and my kids screaming and hollering, seeing their mother be beat on - it wasn't worth it.

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cont.

Therapist: It wasn't worth it. Wow. I'm amazed by this. How did you do this? I mean, ...

Patient: I just stayed away from him, you know. I was scared of him but, you know, my father always told me, "Be strong," and that's what I did.

Therapist: Really? That's what you did.

Patient: I stayed strong. And every time I saw him I didn't run. You know, I let him make all the threats he wanted. I didn't run. There wasn't a need for running. 'Cause you know you can't run forever.

Therapist: That is true. Wow. so lots of things happened to you, right? More than most women go through in their lifetime.

Patient: Some women, as you said before...they'll stay wit their person, but there is no way that I can stay with a man that's going to constantly keep beating on me, 'cause I don't like to be beat.

Therapist: Of course not.

Co-Constructing a Sense of What the Client Wants

Therapist: So it's two years since you've seen him. And you want your children back. But in order to get your children back you had to do this. Social service said you had to get Marvin out of your life.

Patient: Right.

Therapist: And you have done that.

Patient: Yes, I have.

Therapist: And what's the next piece you have to do?

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cont.

Patient: Get my kids back. My kids are very important to me.

Therapist: Right. O.K. Where do I come in on all this? How can I help? 'Cause, you know, it sounds like...you were able to get Marvin out of your life - even though that was very tough. And I wonder how I can help you with your depression and your stress.

Patient: You know, I have a lot of things on my mind. Sometimes I am scared.

Therapist: Of?

Patient: I am scared to walk out of my house.

Therapist: Because of Marvin?

Patient: Right.

Therapist: So you are still afraid of him? O.K. And you don't want to be scared anymore? Is that what you mean?

Patient: Right.

Therapist: What else? How do you want things to be different?

Patient: I just want my kids back.

Therapist: You "want your kids back." Right. What do you have to do so that ... what do they tell you that you have to do?

Patient: I had to go to a meeting or meetings. At the meetings we talk about abusive relationships and stuff like that.

Therapist: Uh huh.

Patient: And that's it.

Therapist: That's it. How helpful is going to that meeting?

Patient: It's O.K. We have it every Tuesday and Thursday.

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cont.

Therapist: Uh huh.

Patient: And it's helping me a lot.

Therapist: What about the meeting is helpful?

Patient: You know, they take a lot of things off my mind. We talk about the abusive relationships and how abusive men are and stuff like that.

Therapist: Does it help you to keep Marvin away from your life?

Patient: Yeah, it relieves me, you know.

Therapist: It does?

Patient: It takes it off my mind and stuff.

Therapist: So, that's been helpful. What else has been helpful?

Patient: My father. You know, he talks to me and stuff. He told me, "Don't be scared. Just leave it in the Lord's hands."

Therapist: Yeah.

Patient: And, you know, he'll make a way for that person just to leave me alone. Not physically or mentally, but he'll just make a way for that man to leave me alone. And that way every tome he sees me he won't harm me or hurt me. He'll say, "Hi, how I'm doing," and keep going.

Therapist: Yeah, I see. So your father gives this kind of advice to you. It sounds like he's very helpful to you.

Patient: Yes.

Therapist: What else has been helpful?

Patient: Social workers. They give me advice. And, you know, they always, cause I

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cont.

always talk about my kids and they always tell me don't say I'm not going to get my kids back, 'cause they'll be home real soon.

Therapist: And that's helpful - to hear that, that they're gonna be home soon?

Patient: Right, And they told me the next time I get involved with a man, sit back and watch how that man treats his mother, and then I know how he would treat me.

Therapist: Right. So is that what you're going to do next time?

Patient: Uh huh.

Therapist: So you remember a lot of things it sounds like?

Patient: Yes.

Therapist: Good. I want to come back to this. What can I do that would be helpful? It sounds

like you do know, you're doing lots of things, you have done lots of things.

Patient: Just help me see it through. Give me some advice.

Therapist: On?

Patient: Help me be strong.

Therapist: Be strong. Sounds like you already are, though.

Patient: I think I am.

Therapist: I mean, if you could stand up to Marvin.

Patient: It was something hard to do.

Therapist: Oh, I'm sure it was very hard. I'm sure it wasn't easy. But somehow you managed to get Marvin out of your life. And that's no small accomplishment. Wow. You said you don't want to be depressed anymore, and you don't want to be stressed

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anymore. Let me come back to this. I'm going to ask you a very strange question - I have a lot of these strange questions; maybe you never heard them before. Let's say after you and I talk and whatever you do for the rest of the day and you go to bed tonight and when you are sleeping a miracle happens. And the miracle is the problem that brought you here today to talk to me - about how you want your children back and how you want to be stronger. And all these things happened because of this miracle. All the problems that are related to your children, related to Marvin...are solved. But this happens when you're sleeping tonight, so you don't know that the miracle actually happened. The problem that brought you here is gone, it's solved, it's all taken care of. So, when you wake up tomorrow morning, how will you find out...what will make you say, "Wow, maybe something happened in the middle of the night when I was sleeping; maybe there was a miracle?" How will you be able to say or tell that tomorrow morning?

Patient: How would I be able to tell that?

Therapist: Yeah.

Patient: To be honest, I wouldn't know. If a miracle were to happen to me, I wouldn't know how I'd tell it, I'd just be excited.

Therapist: O.K. That makes sense.

Patient: So I couldn't tell you how I would be able to tell. I'd just be excited, happy.

Therapist: O.K., so when you open your eyes, when you're sort of coming out of your sleep in the morning waking up from a deep sleep, what would be the first thing that will make you think, "Wow, something must have happened when I was sleeping."

Patient: If a miracle was to happen to me and I woke up, I hope the miracle would be that

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cont.

my kids would be there when it happened.

Therapist: Ah. So your kids would be in the same place with you, same house with you. That will make you very excited.

Patient: Yes.

Therapist: Good. So suppose that happened.

Patient: I'd be excited. I'd jump for joy!

Therapist: Jump for joy. Great. So suppose you're jumping for joy, you are very happy. That means you are very cheerful, right?

Patient: Uh huh.

Therapist: You move, you'd get up, right?

Patient: Right.

Therapist: You'd be excited to get up in the morning and do things.

Patient: Yes.

Therapist: What would your children be like?

Patient: They'd be happy to see me.

Therapist: They'll be happy to see you. O.K.

Patient: They won't have to worry about nobody else raising them. They know who their mother is.

Therapist: Yeah, I understand they're in a foster home.

Patient: Right. And they wouldn't have to worry about no strange person, you know, telling

them what to do and stuff like that.

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Therapist: Right, O.K. And so they will be happy and you will be happy. You'll be excited and they'll be excited to be back with Mama.

Patient: Yeah, and no strange person laying next to them.

Therapist: O.K., so there will be no strange person laying next to them.

Patient: It'll be their mother.

Therapist: Right, it'll be you. What would you do then? What would be the first thing you would do in the morning when this all happened?

Patient: I'd grab my kids, give them a hug, tell them I love them. Tell them how much I love them. And how glad, you know, how glad I am to have them back home with me.

Therapist: And what would they be like?

Patient: They'd be happy.

Therapist: They'd be happy, too.

Patient: Big smile on their face.

Therapist: And you want to see that.

Patient: Yeah.

Therapist: I suppose they want to see you smile too, right? They want their mama to be happy.

Patient: Yes.

Therapist: What else will be different when this actually, you know, suppose this actually happened?

Patient: If it happened things would change for me. I won't be depressed anymore. I won't have to worry about being stressed out anymore 'cause my kids ain't there with

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cont.

me.

Therapist: Right. What would you be like instead?

Patient: I'd feel like a mother should feel.

Therapist: What's that?

Patient: 'Cause, you know, without your kids, it's a hurting feeling when your kids get taken from you. You know, it hurts.

Therapist: Sure.

Patient: And I'd just be one happy parent. you know, one happy mother.

Therapist: And so, when you are not depressed anymore you'll be happier, you'll be a happy mother. What else?

Patient: I'd be thankful.

Therapist: Oh, you'd be thankful. To whom?

Patient: That I have my kids back. You know, I won't have to worry about going through that... or sitting there worrying about when I'm going to get my kids back, when are these people going to give me my kids back. And are my kids going to stay gone forever, and all that...

Therapist: Oh, so all hat will be gone from your head?

Patient: Right.

[Add stuff here to extend the miracle picture...p.383]

Therapist: What would you do with your children that would tell them that you are happy to have them home?

Patient: I'd have fun with my kids. Play with them, read to them, you know, take them

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cont.

places.

Therapist: So you would take your children places?

Patient: Yeah, I would do things for my kids. Do the things that they want - so that they are happy.

Therapist: It sounds like you would get a lot of enjoyment giving things to your kids, where did you learn to be such a good, loving mother?

Patient: I don't know. I guess maybe from when I was taking care of my younger siblings.

Therapist: You cared for your brothers and sisters?

Patient: My parents worked a lot. Being the oldest child, I had to help them out. I started when I was 8 or 9.

Therapist: Wow, so you have had a lot of experience caring for children.

Patient: Yeah, I guess I have.

Therapist: I bet you have a lot of parenting skills that many mothers don't have.

Patient: Yeah I guess so...I also learned a lot from my parents. They taught me a lot.

Therapist: It sounds like they were good role models for you.

Patient: Definitely. They have been helpful throughout my whole life.

Therapist: I bet they taught you a lot of things about parenting?

Patient: Yeah, I remember my mother teaching me things like how to feed a baby and how I should discipline the kids when they are bad.

Therapist: I bet learning those specific skills were helpful.

Patient: They were. And my father still helps me with certain things.

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cont.

Therapist: So it seems that your parents have been there to teach you things at different points throughout your life.

[Back to the actual script]

Patient: I've been through a lot.

Therapist: Sounds like it. But you also learned a lot. Wow. Amazing. So, you know, I'm amazed by this again. Year and a half, this year and a half, two years with Marvin and with your having your children taken away. That has not been easy.

Patient: And then, you know, well I got in a relationship with him after my little sister was buried. So, I guess that's what made it worse.

Therapist: Your sister was buried?

Patient: My 13-year-old sister. She died of asthma.

Therapist: Wow. So I guess you're right, you have been through a lot. So in the middle of all this, how did you learn to be so strong?

Patient: I got a best friend, you know, somebody that's been there for me, somebody that I don't have to worry about her turning her back on me. And when I have problems I know who I can go talk to. You know, somebody who's just going to be there for me.

Therapist: And you had a friend like that?

Patient: Right, she's still my friend.

Therapist: And you also said your father was very helpful?

Patient: Right, you know, they were there. They were by my side. you know, they were in my corner.

Therapist: They were in your corner. And that helped?

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cont.

Patient: Uh huh.

Therapist: So knowing that they were in your corner with you, what about that was helpful?

Patient: They just helped me, they helped me focus, keep my mind off a lot of things. Just told me, "Don't worry about it. Be strong." Told me I was going to get my kids back real soon.

Therapist: Reminding you that you were going to get your kids back, that was helpful, you say?

Patient: Yeah.

Therapist: Was there anything that you did that was helpful?

Patient: I went to see my kids all the time. I had them every weekend and stuff like that. You know, I was always there for them.

Therapist: Oh, right, so you stayed in touch with them.

Patient: Let them know who their mother is, you know. So when I do get them back, they won't think I'm some stranger or nothing like that.

Therapist: Right. So you made sure that they knew that you're their mother.

Patient: Right.

Therapist: Good. What else did you do to help yourself to stay strong?

Patient: I stayed in the meetings.

Therapist: You stayed in the meetings. O.K.

Patient: And I was always with my social worker. You know, something that would keep my mind off of everything. I moved around a lot.

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cont.

Therapist: So, try to keep busy and...

Patient: Right, and just keep my mind off a lot of stuff.

Therapist: Keep your mind off a lot. So, let me come back to this, how did you overcome this fear of going outside and fear that maybe Marvin is, you know, might be jumping on you and stuff like that? How did you learn to overcome that?

Patient: Well, like I said before, you know, you got to be strong. And my father always told me to put it in God's hands. He told me I'm one of God's children; I can't be harmed.

Therapist: Really.

Patient: And I took his word for it.

Therapist: When you heard this from your father, you put that into practice?

Patient: Right.

Therapist: You knew how to make it work for you?

Patient: Right.

Scaling: Measuring Client Constructions of Competence

Therapist: Let me ask you this, let's say on a scale of 1 to 10, 10 stands for how you will be when you finally get your children back, and 1 is what you were like when your children were taken away from you. Remember those days? How bad you felt?

Patient: Yeah.

Therapist: Where would you say things are today?

Patient: I'd say between 8 and 9.
Therapist: Between 8 and 9? Woah? How'd you do that? I mean that's a lot of

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cont.

improvement. Isn't it? I mean how you felt from here to all the way up here? (Gestures)

Patient:Yep. I see it. I see my kids coming back home any day now.

Therapist: Oh, you can see it.

Patient: And I can feel it. I know it.

Therapist: I see. Wow. That's a lot of improvement. What about your father? If I were to ask your father, where he thinks Sally is between 1 and 10 if 1 was what he saw you were like when

your children were first taken away. He knows you very well, right?

Patient: He might say 10.

Therapist: He might say 10. So he also agrees with you that you've come a long way.

Patient: I see it, you know, 'cause my grandmother, she's a, you know, she's a Christian lady. And she told me, she said she can see it and she can feel it, my kids will be home soon. I call my grandmother all the time and that's all I talk about - my kids. She prays with me over the phone.

Therapist: She does? So your grandmother also sees, she can feel that the children are coming home.

Patient: My kids are coming home.

Therapist: So you believe her. You are surrounded by some good people.

Patient: Yeah.

Therapist: O.K. In your mind, then, what needs to happen? Your dad, your father thinks that you already are at a 10. But in your mind what needs to happen so that you can be up to a 10?

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Patient: Continue seeing my kids. Paying them visits. Gettin' them on the weekends and continue my meetings. And they'll be there.

Appendix G
Cognitive Therapy Video Script

Cognitive Therapy Video

Background Information

-19 year old

-Mother of 2 children (ages 3 and 4)

-Children removed by protective services 18 months prior

-Referred to therapy by social services

-Currently feeling "depressed and stressed out"

Structure of the Session

1) Brief Update - Mood check

2) Set Agenda

3) Discuss Issues

Automatic Thought #1 "I am not strong enough to get my kids back"

For: Haven't gotten them yet

For: Cry a lot - Feel down

Against: Got away from Marvin

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cont.

Against: Been through tough things before

Automatic Thought #2 "I'm a bad mother"

For: Weird looks from neighbors

For: Put the kids in a dangerous situation

Against: Social worker says things are going well

Against: Changes made in my life

a) Got away from Marvin -- 2 years

b) Attend all of the meetings for abusive relationships

c) Not as afraid to go outside

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Cognitive Therapy Video Script
cont.

Brief Update - Mood check

Therapist: Hi, Sally. How are you feeling today?

Patient: A little better, I think.

Therapist: Good. On a scale of 1 to 10, 1 being no depression and 10 being a great deal of depression, rate your depression over the past week.

Patient: I would say about a 6 or so.

Therapist: Okay, tell me how your week went.

Patient: Well okay in some ways, but there were other things that were not so great.

Therapist: Tell me more about both the good and bad aspects of the past week.

Patient: Well, I've been feeling a little less depressed, I think. But a lot more stressed. I've been so worried about getting my kids back that I couldn't concentrate.

Therapist: Should we talk about that today?

Patient: Yeah. I think that would be a good idea... I also had a problem with my brother.

Therapist: Okay, I'll write both of these items down to talk about. Anything else I should know about your week?

Patient: Um...I guess not.

Therapist: Okay, back to the mood check. What might account for you feeling less depressed?

Patient: I've been feeling a little more hopeful. I guess I think therapy might be helping.

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Cognitive Therapy Video Script
cont.

Therapist: So you had thoughts like, "Therapy might help," and those thoughts made you feel more hopeful, less depressed?

Patient: Yes...And I talked with Lisa - she's my neighbor - about what I have to do to get my kids back. We spent a couple of hours yesterday going over everything. That made me feel better, too.

Therapist: What went through your mind when you were talking with her?

Patient: That I liked her. That I was glad I talked with her...I feel better now.

Therapist: So we have two good examples of why you felt better this week. One, you had

hopeful thoughts about therapy. And two, you did something different - talking with Lisa - and that also made you feel good.

Patient: Yeah.

Therapist: Can you see how in these two cases your positive thoughts affected how you felt this week?

Patient: I guess so.

Therapist: I'm glad you're feeling a little better. I want to come back to these ideas and also talk about the course of improvement later in this session.

Setting the Agenda

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cont.

Therapist: Now we should set the agenda for today. Besides talking about the course of improvement, the problem with your brother, and thoughts about getting your kids back, is there anything else we should address today?

Patient: Well...I just want my kids back.

Therapist: Okay, lets talk about that. What are the things that you need to do in order to get your kids back?

Patient: Well I have to keep strong and stay positive.

Therapist: That is definitely a big part, isn't it?

Patient: Yeah it really is.

Therapist: Okay, what other things do you need to accomplish?

Patient: ...I just have to prepare to be a mother again.

Therapist: So in order to get your kids back, you need to keep strong and prepare for their return. Is there anything else?

Patient: No those are the two things I always think about.

Therapist: So we have identified many possible things to work on today including trying to stay strong, trying to be the best mother that you can, and a problem with your brother.

This is a pretty ambitious agenda. If we run out of time, is there something we can put off until next week?

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cont.

Patient: Ummm... I guess the problem with my brother. It'll probably just blow over. Besides, the other things will help me get my kids back.

Therapist: Okay, we'll put the problem with your brother last on our list and we'll try to get to it, but if not, we'll talk about it next week, if it's still relevant.

Patient: That sounds ok.

Discussion of the Issues on the Agenda

Therapist: Good, let's take a look at the agenda. Where do you think we should start? We could talk about staying positive and being strong or preparing for your kids return?

Patient: Let's start with my trying to stay positive. This comes up all the time.

Therapist: It does? How has this come up during the past week?

Patient: Well, a couple of times this week I was feeling down about not having my kids around. It seems like people always can tell when I feel like this, and they tell me that I have to stay strong.

Therapist: So other people tell you that you need to be positive when you are feeling down.

Patient: Yeah. My father tells me that all the time.

Therapist: What happens when he tells you to stay positive?

Patient: I guess I feel a little bit better. He usually reminds me about the good things.

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cont.

Therapist: So it sounds like it is helpful for you when other people, especially your father, tells you to keep thinking positive.

Patient: It is kinda helpful, but it is also...like I am a little child...Like I can't take care of myself. Therapist: It sounds like that in some ways, other people telling you to think positive actually makes things worse.

Patient: Yeah it does. It makes me feel better at first, but after awhile it usually makes me feel even more down.

Therapist: So in a nutshell, when you are feeling down, people approach you and tell you to stay

positive. This seems to help a little bit. But, it also sounds like these experiences leave you very frustrated and seem to make you feel worse.

Patient: Yes. Exactly.

Therapist: Ok lets examine the connection between your thoughts and feelings about trying to stay positive. Can you think of some specific times this week when you felt upset like you described?

Patient: Yeah, sure...last night.

Therapist: What time was it? Where were you?

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cont.

Patient: It was about 7:30. I was at home in the kitchen. A little earlier in the evening I was feeling bad and my father noticed. He came up and put his arm around me. He said "You just have to stay positive Sally. You got to hang in there." It made me feel better, but later when I was in the kitchen by myself, I just felt worse.

Therapist: Ok, it was 7:30 and you were in your kitchen. What emotion were you feeling?

Patient: ...I just felt bad.

Therapist: Let's try and clarify that a bit. Would you say you were sad? Anxious? Angry? something else?

Patient: I guess I was feeling sad.

Therapist: Can you picture it in your head now? It's 7:30, you are in your kitchen, you're feeling sad...What thoughts go through your mind?

Patient: I was thinking about my kids.

Therapist: Good. What were you specifically thinking about?

Patient: That they aren't with me...They are living with someone else and I am trying to get them back.

Therapist: How are these thoughts contributing to your sadness?

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cont.

Patient: I'm really worried that...I'm not strong enough to get my kids back.

Therapist: Okay. You just identified what we call automatic thoughts. Everyone has them. They're thoughts that just seem to pop in our heads. We're not deliberately trying to think about them; that's why we call them automatic. Most of the time, they're real quick and we're much more aware of the emotions - in this case, sadness - than we are of the thoughts. Lots of times the thoughts are distorted in some way. But we react as if they're true.

Patient: Hmmm. So you're saying I am having bad thoughts?

Therapist: Not exactly. When you described ideas such as "I'm not strong enough to get my kids back" you identified one type of thought that many people experience, called an automatic thought. In fact, automatic thoughts are very common. These thoughts tend to arrive so quickly, that the focus is put mainly on the emotions that are tied to them. In your case the emotion seems to be sadness. Following me so far?

Patient: That part makes sense, but you said something about bad or distorted thoughts?

Therapist: Well, many times, these automatic thoughts are not completely accurate. They may contain some aspects of truth, but they also are likely to be somewhat misleading. Because these thoughts have some part of the truth but also some inaccuracies, we call them distorted.

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cont.

Patient: So what you're saying is that these thoughts describe parts of my life - so I feel that they are true. But they also have parts that are bad, no..."inaccurate."

Therapist: Right, and these automatic thoughts, with their "inaccurate" information, often bring with them negative emotions that can cause problems.

Patient: Okay. That makes sense.

Therapist: What we'll do is to teach you to identify your automatic thoughts and then to evaluate them to see just how accurate they are. For example, in a minute we'll evaluate the thought, "I'm not strong enough to get my kids back." What do you think would happen to your emotions if you discovered that your thought wasn't true? What would be the emotional consequences of thinking to yourself, "I am capable of doing what I need to do to get my kids back?"

Patient: I'd feel better.

Therapist: On the other hand, when you have the thought "I'm not strong enough to get my kids back" you feel sad. Do you see how what you are thinking influences how you feel?

Patient: Uh huh.

Therapist: That's what we call the cognitive model. This is a lot of information to get all at once. So I know that you and I are on the same page, could you tell me in your own

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cont.

words about automatic thoughts and the cognitive model?

Patient: (Exhale) Oh boy, I'll try. First, there are these automatic thoughts that everybody has. These thoughts are real quick and just pop into our heads. However, we usually don't focus on the thoughts, but on the emotions that come along with these automatic thoughts.

Therapist: Great. Good job so far - what else?.

Patient: Now these automatic thoughts often have a part that is "inaccurate." What was the word that you used? It wasn't bad, it was...

Therapist: Distorted?

Patient: Yes, these automatic thoughts are often distorted. Because they are distorted, they often bring negative emotions along with them, like anger or sadness.

Therapist: Good. So how are we going to try and help you with your automatic thoughts?

Patient: We're gonna test my automatic thoughts to see if they are true or not. If they are not true, I may be feeling sad for no good reason.

Therapist: Right, what we'll do in therapy is to teach you to identify your automatic thoughts when you notice your mood changing. That's the first step. We'll keep practicing it, until it's easy. Then you'll learn how to evaluate your thoughts and change

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cont.

your thinking if it's not completely correct. Is that clear?

Patient: I think so.

Therapist: So step 1 is to identify your automatic thoughts. Step 2 is to evaluate and respond to those thoughts. Could you tell me back in your own words about the relationship between thoughts and feelings?

Patient: Sometimes I have thoughts that are wrong and these thoughts make me feel bad...But what if the thoughts are right?

Therapist: Good point. Then we'll do some problem-solving or find out what's so bad about the thoughts if they are true. My guess, though, is that we'll find a lot of errors in your thinking because negative thinking is always part of depression. In any case, we'll figure out together whether your interpretations are inaccurate. So, now, let's look at the first thought together. What evidence do you have that you are not strong enough to get your kids back?

Patient: Well, I have been working on getting them back for a while now and I still haven't got them back yet.

Therapist: Okay, what other evidence is there?

Patient: Well...its just so tough without them....I cry a lot about this.

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cont.

Therapist: It sounds like it is really hard for you without your children.

Patient: Yeah it really is...[pause]

Therapist: Is there any other evidence that you are not strong enough to get your kids back?

Patient: No...Just that I don't know how long I will be able to keep this up.

Therapist: Okay. Now that we've listed some evidence that supports your belief, let's look for evidence that doesn't support it. Any evidence that you are strong enough to get your kids back?

Patient: Well, I got away from Marvin.

Therapist: That was a big thing for you wasn't it?

Patient: It sure was. He didn't want to end it, but I had a restraining order put on him. I had to do something. He was threatening me, threatening to kill me...

Therapist: Wow. It sounds like you were able to be strong in that difficult situation.

Patient: Yeah. I guess so.

Therapist: Good. What else?

Patient: Well, I have really been through a lot and I am still here. My little sister died of asthma when she was 13. I was in an abusive relationship with Marvin. I'm still here. I'm still trying to get my kids back.

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cont.

Therapist: Good insight. What other evidence is there that suggests you will be able to

stay strong?

Patient: ...I can't think of anything else.

Therapist: What other thing did you already tell me that you did this week to try and stay strong?

Patient: Oh yeah, I talked with Lisa. Yeah, that was helpful.

Therapist: So, in a nutshell, you think that you are unable to stay strong because you haven't gotten your kids back yet and you cry a lot about this situation. However, on the other hand, you indicated that you were able to leave an abusive relationship and you have been able to stay strong even after the death of your sister. In addition to these things, you have been able to identify someone to talk to in order to help you through the process. With all of this in mind, what do you think of your prediction that you're not strong enough to get your kids back?

Patient: It seems a bit silly.

Therapist: Can you explain what seems unrealistic about the thought we've been evaluating?

Patient: It seems like the bad things aren't actually that bad. I guess I was able to be

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cont.

strong through a difficult situations.

Therapist: With that in mind, how do you feel now?

Patient: I guess I am a little less worried.

Therapist: Okay, to summarize, you had the automatic thought "I'm not strong enough to get my kids back" this week which made you feel bad. But when you stop to evaluate these thoughts rationally, it seems that there are a number of things that suggest you will be able to stay strong. When you really look at the evidence and answer back the thoughts, you feel at least slightly better...Is that right?

Patient: Yeah, that's true.

Therapist: Good. It sounds like this exercise was useful. Let's move on with the agenda. You mentioned you also wanted to talk about preparing for the return of your children.

Patient: Yes. That has been on my mind a lot lately.

Therapist: Tell me what you have been thinking about.

Patient: I guess I am doing all of the right stuff...(Physical change).

Therapist: I just noticed a change in your facial expression...what were you thinking about?

Patient: I have been trying to do all of the things that I need to in order to get my kids back. I have been doing everything that the social worker, my parents, my friends tell

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cont.

me...but all that kinda makes me feel worse..

Therapist: What's happening that makes you feel worse?

Patient: I feel like...like other people look down on me because my kids were taken away.

Therapist: Tell me more about that.

Patient: Well...there are always people hanging around my building. Usually when I go in and out or to the laundry, I see them. None of these people say "hi" to me, smile at me, or anything.

Therapist: Do you feel like they are ignoring you?

Patient: No. I feel like they don't want to talk to me because I am a bad person. They must know that my kids are gone. I bet they think I am an awful person because I can't take care of my kids.

Therapist: So when you come and go, you pass other people who don't acknowledge you and you believe that they are acting this way because they know your kids have been taken away.

Patient: Uh-huh.

Therapist: When you feel that these other people are looking down on you, what are you thinking?

Patient: I feel awful.

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cont.

Therapist: What do you mean when you say that you are feeling awful?

Patient: I just feel awful. I can't explain it more.

Therapist: Okay, think of the situation. You are passing the other people on your way out of your building. What thoughts are you having in this situation?

Patient: They all think that I am a bad person.

Therapist: What does this make you think about yourself?

Patient: That I am a bad person...or worse. That I am a bad mother.

Therapist: When you think "I am a bad mother" what emotions do you feel?

Patient: I feel lower than low, the absolute worst.

Therapist: Lets examine this automatic thought of "I am a bad mother" like we did the last one. How much do you believe this thought when it occurs?

Patient: I guess about 70-80%

Therapist: Just like before, lets look at the accuracy of the thought, "I am a bad mother." What evidence was there that this thought was true, that you think you really are a bad mom.

Patient: Well, nothing specific. But the way people look at me - like I can't be a good parent.

Therapist: So the way people look at you supports your negative thoughts, what other evidence...?

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cont.

Patient: Well, I put my kids in a dangerous situation by being with Marvin.

Therapist: Tell me more about that.

Patient: Marvin was abusive to me and my kids. He broke my son's leg.

Therapist: That sounds like a horrible situation.

Patient: Yeah, it really was.

Therapist: So, being around Marvin and his abuse of you and your kids makes you feel like you are a bad mother?

Patient: Yeah. I have to be a bad mother to let that happen to my son.

Therapist: You have identified two reasons why you feel like a bad mother. Besides the looks that people give you and staying with Marvin through the abuse, what other evidence is there that you are a bad mother?

Patient: That's it. Isn't it enough?

Therapist: It does sound like each of those things is very powerful. Maybe we can gain some perspective by looking at the other evidence. What evidence is there that you are not a bad mother?

Patient: I don't know. I can't think of anything.

Therapist: I'm sure there are some things. Think about the people in your life. Are there

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cont.

people in your life that might think that you are not a bad mother?

Patient: Well, my social worker says I am doing really well. At our meetings she tells me that she understands that I was in a difficult situation and that I really do love my kids. She keeps telling me that I will get my kids back.

Therapist: Wow. That is quite a vote of confidence.

Patient: Yeah, after she got to know me, she really became supportive of me getting my kids back.

Therapist: Great. What other evidence is there that goes against the idea that you are a bad mother?

Patient: Well my father and my grandmother each tell me that I will get my kids back.

Therapist: Okay, so they are supportive of you.

Patient: Yeah, but they are family - so it kinda seems like they have to tell me these things.

Therapist: Okay, what else...

Patient: ...I can't think of anything else. I don't think anything else makes me feel like I am a good mother.

Therapist: Let's look at this another way. Why do you think that your social worker tells you that you are doing so well.

Patient: She is really happy that I have gotten away from Marvin. You know I have been

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cont.

away from him for almost 2 years!

Therapist: Good. What else is she happy about?

Patient: I am not as afraid to go outside anymore. I used to be really afraid that I would run into Marvin on the street. But I have gotten over most of that. Oh, I have also been attending these meetings about abusive relationships. I guess a lot of people skip them, but I have been to everyone.

Therapist: So your social worker thinks you are making progress because you have gotten away from Marvin, and stayed away for 2 years, attended all of the meetings about abusive relationships, and overcome your fear of running into Marvin on the street. All in all, they sound like some significant life changes.

Patient: Yeah I guess they are.

Therapist: So when you look at these things, do they seem like things that go against your idea that you are a bad mother?

Patient: I haven't thought about this before...I am not sure about what these things have to do with me being a mother, but they sure have improved my life.

Therapist: O.K. How have these things improved your life?

Patient: I'm away from Marvin. That is clearly a good thing. He can no longer hit me or my kids.

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cont.

Therapist: That sounds like a big improvement. What about the other things?

Patient: Well...the classes have taught me a lot about bad relationships and how to stay out of them in the future. That has been a big help.

Therapist: That sounds like a big improvement in your life to know that you can avoid abusive relationships in the future.

Patient: It does make me feel a lot better about my future. It also helps that I am not so scared to go outside and run into Marvin. I guess in that way my life is getting more normal. I am able to go and do the things that I need to.

Therapist: So your life has improved by getting away from an abusive man, learning about abusive relationships, and getting your life back to normal.

Patient: Uh huh.

Therapist: So how do these improvements relate to you as a mother?

Patient: If these things are good for me, they are good for my kids. If I make my life better, I can be a better mother for them.

Therapist: Great. What do these improvements in your life say about how you will protect your kids from men like Marvin?

Patient: I guess each of those things make it less likely that I will put my kids in another abusive situation. That definitely makes me a better mother.

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cont.

Therapist: Good. Now lets put everything together that we have talked about. With regards to your thought that "I am a bad mother" you identified the looks that other people give you and putting your kids in a dangerous situation with Marvin. However, your social worker had some very good things to say about your current level of parenting skills that don't fit with the automatic thought "I am a bad mother." Also you just concluded that you have made many changes in your life that make you a better mother by preventing the dangerous situations in the future. When you put all that together, what do you think about the idea "I am a bad mother?"

Patient: It doesn't seem like there is a lot to support that "I am a bad mother." I understand how I have made changes to prevent getting into another abusive relationship, but what about the way people look at me?

Therapist: That is a good point. Let's look at the situation again. Could there be other explanations for the way that you see people looking at you?

Patient: They look at me weird because they know my kids have been taken away.

Therapist: Think of other situations in your life, are there any times where people look at you in a different way than you are expecting.

Patient: Of course.

Therapist: In those situations, what are some reasons why people would look at you in a

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Cognitive Therapy Video Script
cont.

strange manner.

Patient: Maybe they're just rude people to begin with...or maybe they are having a bad day.

Therapist: Okay, so do you think that there is a possibility that the people you see before going into your apartment are rude or having a bad day?

Patient: I guess so...

Therapist: How would you know if these people are rude or if they are having a bad day?

Patient: I don't know these people and I wouldn't know what they are thinking.

Therapist: So you are saying that there is no way to know what they might be thinking.

Patient: Yeah, I guess so.

Therapist: So you don't really know if people at your apartment building are unfriendly because of what they are thinking about you, or if they are unfriendly for other reasons, like just being rude or having a bad day or not knowing you well enough to say hello...

Patient: I would have no way to tell.

Therapist: Okay. With that in mind, do you think they are judging you or could there be other things going on?

Patient: When you put it that way, there might be other things going on. I guess I can't be so sure that these people are having bad thoughts about me.

Therapist: Okay, we have evaluated your automatic thought "I am a bad mother" and it

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cont.

sounds like there isn't much evidence to support that thought

Patient: It seems that way now.

Therapist: Okay, how much do you believe the thought " I'm a bad mother?"

Patient: About 10%

Therapist: Great. Now let's look at how this automatic thought impacted your life. What is the effect of your thinking about the thought "I'm a bad mother"

Patient: It makes me miserable.

Therapist: What could be the effect of changing your thinking?

Patient: I wouldn't feel so bad. I'd feel better.

Therapist: How would you feel better?

Patient: I guess I would be more hopeful and less discouraged.

Therapist: Good. It sounds like evaluating this thought really helped.

Course of Cognitive Therapy

Therapist: Okay, we just finished talking about two of your automatic thoughts. We evaluated your automatic thoughts "I'm not strong enough to get my kids back" and "I am a bad mother." We determined that these automatic thoughts were unrealistic and creating additional stress for you. Next, I'd like to talk about the course of getting better, if that's okay.

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cont.

Patient: Sure.

Therapist: I'm glad you're feeling a little less depressed today, and I hope you continue to feel better. But probably you won't just feel a little bit better every single week until you're back to your old self. It would be realistic for you to have ups and downs. Now I'm telling you this for a reason. Can you imagine what you might think if you expected to keep feeling better and better and then one day you felt a lot worse?

Patient: I'd probably think I would never get better.

Therapist: That's right. So I want you to remember that setbacks are a normal part of getting better....END

Appendix H
Consent Form

SUBJECT INFORMATION AND CONSENT FORM

TITLE: The relationship between personality and the formal helping process.

INVESTIGATOR: Shannon Woulfe, M..A.
318-319 Corwin-Larimore Bldg
Office phone -- 777-3326

Purpose: The purpose of this research study is to examine perceptions of two distinct forms of psychotherapy.

Procedures: If you agree to take part in this research, you will be asked to view two video clips and complete three packets of questionnaires. Each video clip displays a portion of a therapy session between a psychologist and a 19-year-old woman. Some of the issues discussed in these video clips include child abuse, spousal abuse, and the concerns of day-to-day living. Following each of the video clips, you will be asked to complete a packet of questionnaires about your reaction to the videos. After the completion of these tasks, you will also be asked to complete a third set of questionnaires about your reaction to the videos and also about your personality. It is expected that it will take approximately 2 hours to participate in this study.

Payment for Participation: In exchange for your participation in your study, you will receive extra credit in your psychology course equivalent to two hours of research participation.

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cont.

Risks/Discomforts: Through your participation in this study, you may learn about different helping relationships. With this new information, you may negatively evaluate the helping relationships that currently exist in your life. Also, observing another individual discuss her problems in a therapeutic setting may cause you to think about feelings that make you sad or upset. Additionally, you may experience the discomfort some people feel when they disclose information about themselves.

If you experience any discomfort associated with your participation in this study, the following agencies may be of assistance:

UND Psychological Services Center, at 777-3691
UND Counseling Center, at 777-2127
UND Family Practice Center, at 777-6800

Benefits: This research may eventually benefit society from the knowledge gained from understanding opinions about different forms of psychotherapy. However, it is unlikely that you will directly benefit from this study.

Confidentiality: The purpose of this study is to examine data in aggregate form, and the information provided by any one participant is not of interest. Therefore, there will be no connection between your identity and your responses on the questionnaires. Further, your signed consent form will be stored in a location separate from the completed questionnaires.

Voluntary Participation/Withdrawal: Your decision to take part in this research study is entirely voluntary. You may refuse to take part in or you may withdraw from the study at any time without penalty.

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Consent Form
cont.

Questions: You are encouraged to ask any questions concerning this research that you have, now or in the future. If you have any questions, please contact:

Shannon Woulfe investigator, at 777-3326
Dr. James Antes, research advisor, at 777-3882
Dr. Mark Grabe, Chair of the Psychology Department, 777-3920

If you have any questions regarding your rights as a research subject, you may contact the UND Office of Research and Development at 777-2049

Statement of Consent: I have read the above description of this research study. I have been informed of the risks and benefits involved, and questions have been answered to my satisfaction. Furthermore, I have been assured that any future question I may have will also be answered by a member of the research team. I voluntarily agree to take part in this research study. I understand I will receive a copy of this consent form.

Today's Date: _____

Name (Please Print): _____

Signature:_____

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