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Noticing Pretreatment Change: Effects on Therapeutic Outcome in Family Therapy

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Utah State University

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NOTICING PRETREATMENT CHANGE: EFFECTS ON THERAPEUTIC OUTCOME IN FAMILY THERAPY

by

Lee N. Johnson

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF SCIENCE in Family and Human Development

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1995
ABSTRACT

Noticing Pretreatment Change: Effects on Therapeutic Outcome in Family Therapy

by

Lee N. Johnson, Master of Science
Utah State University, 1995

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Department: Family and Human Development

Family therapy, similar to other mental health services, has focused on ways to make therapy brief or short term. One model of family therapy, the brief/solutions therapeutic orientation, claims that certain techniques can reduce the number of sessions. This therapeutic model focuses on the solutions clients bring with them to therapy. By focusing on clients' solutions and not their problems, the brief/solutions orientation claims that clients reach their goals more quickly, finish therapy more quickly, and are more satisfied with the services they receive. However, there is little empirical evidence to support these claims. This research specifically looked at the brief/solutions
concept of pretreatment changes (changes clients make before the first therapy session) and the impact that noticing pretreatment changes as a therapeutic intervention had on therapeutic outcome variables of relationship functioning, goal attainment, problem solving, and communication. No evidence was found that noticing pretreatment changes influences therapeutic outcome. Evidence was found that pretreatment changes do not disappear when noticed. Ideas for future research are included.

(89 pages)
DEDICATION

To my wife, Angela, and daughter Micaela. I could not have accomplished this without their love and support.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Dedication</td>
<td>iv</td>
</tr>
<tr>
<td>List of Tables</td>
<td>vii</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Review of Literature</td>
<td>5</td>
</tr>
<tr>
<td>Change in Therapy</td>
<td>5</td>
</tr>
<tr>
<td>Brief Family Therapy</td>
<td>6</td>
</tr>
<tr>
<td>Solution-Oriented Brief Family Therapy</td>
<td>7</td>
</tr>
<tr>
<td>Pretreatment Changes</td>
<td>8</td>
</tr>
<tr>
<td>Important Foci in Family Therapy</td>
<td>10</td>
</tr>
<tr>
<td>Methods</td>
<td>13</td>
</tr>
<tr>
<td>Sample</td>
<td>13</td>
</tr>
<tr>
<td>Instruments</td>
<td>17</td>
</tr>
<tr>
<td>Procedures</td>
<td>22</td>
</tr>
<tr>
<td>Research Questions</td>
<td>28</td>
</tr>
<tr>
<td>Results</td>
<td>31</td>
</tr>
<tr>
<td>Research Question One</td>
<td>36</td>
</tr>
<tr>
<td>Research Question Two</td>
<td>39</td>
</tr>
<tr>
<td>Research Question Three</td>
<td>41</td>
</tr>
<tr>
<td>Research Question Four</td>
<td>42</td>
</tr>
<tr>
<td>Discussion</td>
<td>44</td>
</tr>
<tr>
<td>Summary of Results</td>
<td>44</td>
</tr>
<tr>
<td>Discussion of Results</td>
<td>47</td>
</tr>
<tr>
<td>Limitations</td>
<td>49</td>
</tr>
<tr>
<td>Future Research</td>
<td>51</td>
</tr>
<tr>
<td>Conclusions</td>
<td>53</td>
</tr>
<tr>
<td>References</td>
<td>54</td>
</tr>
</tbody>
</table>
APPENDICES ................................................. 60

Appendix A ................................................. 61
Appendix B .................................................. 74
Appendix C .................................................. 77
Appendix D .................................................. 85
Appendix E .................................................. 87
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Adult Demographics</td>
<td>15</td>
</tr>
<tr>
<td>2 Noticing Pretreatment Change Procedures</td>
<td>27</td>
</tr>
<tr>
<td>3 Instrument Administration Schedule</td>
<td>29</td>
</tr>
<tr>
<td>4 Sample Size for Each Group Across Assessment Occasions</td>
<td>32</td>
</tr>
<tr>
<td>5 Factor Matrix for Problem Solving and Communication</td>
<td>33</td>
</tr>
<tr>
<td>6 $\chi^2$ Values for Demographic Variables Between Dropouts and Nondropouts</td>
<td>34</td>
</tr>
<tr>
<td>7 Means and Standard Deviations of Cases that Dropped Out and Remained in the Study</td>
<td>36</td>
</tr>
<tr>
<td>8 Means and Standard Deviations of Dependent Variables</td>
<td>37</td>
</tr>
<tr>
<td>9 Correlation Coefficients for Dependent Variables at Intake</td>
<td>38</td>
</tr>
<tr>
<td>10 Group T-tests Between Clients Reporting Pretreatment Change and Clients Not Reporting Pretreatment Change for Problem Solving, Communication, Scaling Question, and GARF Scores</td>
<td>40</td>
</tr>
<tr>
<td>11 Percent of Cases that Increased Across Dependent Variables for Groups PT1, PT2, and NP Between Intake and Session Three</td>
<td>41</td>
</tr>
<tr>
<td>12 Means and Standard Deviations for Relationship Functioning and Scaling Question Scores at Intake and After Three Sessions</td>
<td>48</td>
</tr>
</tbody>
</table>
INTRODUCTION

There has been a growing trend towards brief or short-term therapy in the various fields of mental health service. This trend is stimulated in part by (a) insurance companies that no longer pay for expensive long-term therapy (Haley, 1990; Hight & Hight, 1986); (b) the high percentage of people who drop out of therapy before reaching their goals (Kogan, 1957; Talmon, 1990); (c) increased demand for mental health services (Strupp, 1992); and (d) the growing need for therapists to be accountable for their work (Strupp, 1992). At the same time, the number of effective short-term therapy models is increasing. Family therapy is similar to other mental health services in these respects and will continue to focus on more brief methods of therapy and to be influenced by insurance companies' policies (Gurman & Kniskern, 1992), the need for accountability, and the increased demand for family therapy.

One branch of brief family therapy is the brief/solutions orientation that focuses on clients' solutions rather than clients' problems. Although the focus on brief and short-term therapy is expected to continue, there is a lack of empirical evidence to support
solution-oriented brief therapy. One specific area of solution-oriented brief therapy that lacks empirical support is the relationship between client reports of changes that occur prior to treatment and therapeutic outcome.

In the past, pretreatment variables such as age, sex, prior treatment, and pretest scores have been employed as predictors of relapse in the treatment of nocturnal enuresis (Butler, Brewin, & Forsythe, 1990). Pretreatment variables such as age (Lowman, DeLange, Roberts, & Brady, 1984), ethnicity (Acosta, 1980), and previous treatment (Gaines & Stedman, 1981; Hoffman, 1985) have been employed to predict dropout rates from therapy.

Another type of pretreatment variable is change prior to therapy. A pretreatment change is any change clients wish to continue and report making between the phone call requesting therapy and the initial session (Weiner-Davis, de Shazer, & Geingerich, 1987). Pretreatment changes also have been employed as predictors of therapy dropout (Allgood, Parham, Salts, & Smith, 1994; Noonan, 1973).

The use of pretreatment changes in the therapeutic process has yet to be empirically tested. Talmon (1990) states that "patients who can identify (perhaps with the
therapist's assistance) helpful solutions, past successes, and exceptions to the problem that occurred prior to seeking therapy" (p. 31, italics added) may be able to complete therapy in a single session. According to Talmon, by identifying changes that occur "prior to seeking therapy," clients may reach therapeutic goals and complete therapy more quickly. Others also have suggested that pretreatment changes have an effect on therapeutic outcome (Berg & Miller, 1992; Cade & O'Hanlon, 1993; de Shazer, 1991; Lawson, 1994; Miller, 1992; Weiner-Davis et al., 1987).

People have the ability to implement changes on their own. In fact, change is a continuous process (de Shazer, 1989; Kral & Kowalski, 1989). As part of this continuous process of change, clients may implement changes related to solving their problem prior to the first therapeutic session (pretreatment change). Berg and Miller (1992) reported that two thirds of the clients that they have seen reported some form of pretreatment change. In addition to occurring often and being related to the solutions many clients are looking for, information about pretreatment changes can be helpful in reaching therapeutic goals (Berg & Miller, 1992; Lawson, 1994; Weiner-Davis et al., 1987). Even though pretreatment
changes may be a valuable resource in therapy, these changes may not be permanent; if pretreatment changes are not noticed, they may disappear (Miller, 1992).

Although compelling, the above statement lacks empirical support for the relationship between noticing pretreatment changes and therapeutic outcome. Rather than looking at pretreatment variables and changes as predictors of outcome, this research focused on the pretreatment variable of change that clients have experienced prior to treatment, and the relationship between noticing desirable pretreatment changes and therapeutic outcome.

If simply noticing pretreatment changes allows clients to make progress more quickly, then support for an intervention that takes little time to implement will be provided. Also, empirical support for one specific area of solutions-oriented brief family therapy would be provided.
REVIEW OF LITERATURE

The review of literature will explain where the idea of pretreatment change originated and what areas pretreatment changes need to influence to be beneficial. To accomplish this, topics that will be discussed include: (a) change in therapy, (b) brief family therapy, (c) solution-oriented brief family therapy, (d) pretreatment changes, and (e) important foci of family therapy.

Change in Therapy

The process of implementing change in psychotherapy started with the notion of making the unconscious, conscious (Rosenblatt, 1987). This process was carried over into early family therapy by therapists who were trained in individual psychotherapy working with families. Many of the founders of family therapy started the family therapy movement by conducting individual psychoanalysis on more than one family member, or seeing the whole family together. The family therapy interventions then shifted from making the unconscious conscious to altering the interactions of the family (Broderick & Schrader, 1991).
The process of change is viewed differently by various theorists within the field of family therapy. Behavioral family therapists view change as a process of learning new skills or behaviors (Jacobson, 1981). Structural family therapists view the process of change as taking place in the organization of the family by challenging the family's symptom, structure, and reality (Minuchin & Fishman, 1981). Bowen Theory looks at change as a process of learning how to recognize and use differentiation, the emotional system, multigenerational transmission, and emotional triangles (Friedman, 1991). Strategic family therapy views change taking place as the therapist sets clear goals related to the client's presenting problem and devises a plan to solve the client's problems (Madanes, 1991). The ideas of solution-oriented brief therapy emerge from the strategic view of focusing on the client's problems.

Brief Family Therapy

Brief therapy has been described as "Focused Problem Resolution" (Weakland, Fisch, Watzlawick, & Bodin, 1974). Segal and Kahn (1986) further explained the process by which therapists can help clients solve their problems. Therapy
consists of the therapists asking questions that produce an understanding of both the problem and the solutions clients have tried. By collecting this information, the therapist can understand the client's position and set small, clearly stated treatment goals and employ interventions to solve the client's problem. Brief therapy is defined as therapy that is finished in 6 to 10 sessions.

**Solution-Oriented Brief Family Therapy**

de Shazer (1986) extended the ideas of brief therapy with the observation that attempted solutions were examined only in relationship to the ways they maintained the problems, and not for the benefits that solutions have on therapeutic outcome. de Shazer et al. (1986) defined solution-oriented brief therapy as "utilizing what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves" (p. 208). Rather than focusing on what clients are doing that is problematic, therapy becomes a process of looking at what the clients have been doing that is helpful (solutions). It has become important in solution-oriented brief therapy to focus on solutions and/or exceptions to the problem (what
the clients bring with them) (Berg & Miller, 1992; Cade & O'Hanlon, 1993; de Shazer, 1986; de Shazer et al., 1986; Lipchik, 1988). "Exceptions are those behaviors, perceptions, thoughts, and feelings that contrast with the complaint and have the potential of leading to a solution if amplified by the therapist and/or increased by the client." (Lipchik, E., cited in de Shazer, 1991, pp. 83-84). Rather than looking at therapy as a process that focuses on problems and complaints, therapy can be redefined as a process that focuses on nonproblems and noncomplaints (de Shazer, 1991).

Pretreatment Changes

As exploration of exceptions continued, an "accidental" discovery found that exceptions to problems sometimes occur prior to the beginning of therapy, and that identifying these changes is beneficial to therapy (Weiner-Davis et al., 1987). Talmon (1990) concurs that identifying pretreatment changes is beneficial to the therapeutic process but adds that pretreatment changes can shorten the process by not only aiding the client but conveying the message to the therapist that therapy starts before the
first session. Pretreatment changes are not a rare occurrence; it has been reported that if clients are asked about pretreatment changes by the therapist who implies that change has occurred, 67% of 30 clients reported a pretreatment change (Weiner-Davis et al., 1987). Lawson (1994), in replicating Weiner-Davis et al.'s study, found a slightly lower percentage of 62.2% of 82 clients who reported a pretreatment change. The solution-oriented brief therapy orientation claims that the exploration of exceptions/solutions allows therapy to be completed more rapidly and that clients experience a higher degree of satisfaction with therapy. However, empirical evidence to support those claims is rare (Miller, 1994).

One study that provided empirical support was Allgood et al. (1994). In looking at clients who reported pretreatment changes and planned (therapist and client agreed that termination was appropriate) or unplanned termination (terminations initiated by the client), Allgood et al. (1994) found that clients who reported a pretreatment change were more likely to remain in therapy and accomplish therapeutic goals. The Allgood et al. study provides
empirical support for the concept of pretreatment changes influencing therapy.

Important Foci in Family Therapy

In marriage and family therapy there have been many goals for therapeutic outcome. Marriage and family therapy specifically looks at the context in which the problem is presented. This context includes an ongoing relationship with co-workers, friends, or family members (Watzlawick, Bavelas, & Jackson, 1967). In the context of relationships, other areas of importance in family therapy include: (a) working toward clients' goals (Fisch, Weakland, & Segal, 1982); (b) resolving problems (Haley, 1987; Weakland, et al., 1974); (c) patterns of communication (Minuchin & Fishman, 1981; Watzlawick et al., 1967); and (d) focusing on behaviors (Fisch et al., 1982).

As an outgrowth of strategic therapy, in solutions-oriented brief therapy, the contexts of relationships (de Shazer, 1991), goal attainment (Berg & Miller, 1992; Cade & O'Hanlon, 1993), problem resolution (Weakland et al., 1974), communication (Segal & Kahn, 1986), and behaviors (Berg & Miller, 1992) are also important.
This research examined claims that pretreatment changes are beneficial to therapeutic outcome by exploring the relationship between (a) noticing pretreatment change as an intervention and (b) therapeutic outcome in the areas of relationship functioning, goal attainment, problem solving, communication, and behavior control. As stated above, the literature talks about exploring pretreatment changes and noticing pretreatment changes. This study focused on noticing pretreatment change because it can more easily be specified with clear guidelines (i.e., asking about pretreatment changes and assigning pretreatment changes as homework), whereas exploring pretreatment change would vary in terms of its form, the length of time, and the depth of exploration with each therapist. Research questions include:

1. What are the differences between clients who report pretreatment change and those who do not on self-report (Scaling Question scores—a measure of client's progress toward goals; and Problem Solving, Communication, and Behavior Control subscales of the Family Assessment Device) and therapist-report measures (Global Assessment of Relationship Functioning) at intake?
2. What is the difference between noticing desirable pretreatment changes and (a) Global Assessment of Relationship Functioning; (b) Scaling Question Scores (a measure of clients' progress toward goals); (c) Problem Solving, Communication, and Behavior Control subscales of the Family Assessment Device after three sessions and after six sessions?

3. What is the difference between noticing pretreatment change and client ratings of satisfaction with therapeutic services after session three and session six?

4. Does noticing desired pretreatment changes keep those changes from disappearing over a time period of three sessions?
METHODS

Sample

Participants. The participants in this study consisted of all clients requesting therapy at the U.S.U. Marriage and Family Therapy Clinic who consented to participate in the study from August 1994 to June 1995. This time period yielded 63 individual participants and 39 cases ($N = 39$). A case consists of the individual ($n = 10$), couple ($n = 8$), or family ($n = 21$) that requested therapy. Children over the age of 12 filled out forms, and demographic data were gathered on the adults for each case. See Table 1. The people who filled out forms were 71.40% female and 28.60% male. The average age of the adult participants was 30.53 years and on the average the families had 2.60 children. The sample was 96.40% Caucasian. A total of 69.60% of the adult participants had education past high school and 48.30% have earned a degree past a high school diploma. The income of the majority of the participants was below $15,000 (64.30%). This sample is not representative of a national sample on the variables of race (mostly Caucasian), education (mostly higher), and income (mostly lower). Types
of presenting problems included parenting/child behavior problems \( (n = 15) \), marital problems \( (n = 6) \), divorce issues \( (n = 5) \), self-improvement \( (n = 5) \), step-family issues \( (n = 4) \), depression \( (n = 2) \), and premarital counseling \( (n = 2) \). The participants attended therapy for an average of 3.26 sessions. Complete demographics are found in Table 1.

**Therapists.** The therapists \( (n = 12; \ 6 \text{ female}; \ 6 \text{ male}) \) were selected on a volunteer basis from master's-level graduate students at U.S.U. in Family and Human Development specializing in Marriage and Family Therapy. The therapists were all trained in structural, strategic, and brief family therapy orientations. The therapists had experience ranging from over 100 hours of therapy experience \( (n = 6) \), to under 100 hours of therapy experience \( (n = 5) \), and observation of therapy experience \( (n = 1) \). The therapists with over 100 hours of experience conducted therapy on 21 of the cases and the therapists with under 100 hours and observation experience conducted therapy on 18 of the cases. The number of cases assigned to any one therapist ranged from one case to seven cases. Therapists were assigned clients and instructed in the procedures of the study. To control therapist variables, therapists were assigned clients from
Table 1

Adult Demographics

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<th>Variable</th>
<th>N</th>
<th>Percent</th>
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<td><strong>Gender (all participants)</strong></td>
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<tr>
<td>Female</td>
<td>44</td>
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<tr>
<td>Male</td>
<td>19</td>
<td>28.60</td>
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<tr>
<td><strong>Education (adults)</strong></td>
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<tr>
<td>Less than 12 years</td>
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<tr>
<td>High school diploma</td>
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<td>23.20</td>
</tr>
<tr>
<td>Less than 2 year post High school</td>
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<td>12.50</td>
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<td>Greater than 2 years post High school</td>
<td>32</td>
<td>57.10</td>
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<td><strong>Degree (adults)</strong></td>
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<td><strong>Race (all participants)</strong></td>
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<td>Caucasian</td>
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<tr>
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<td>Student</td>
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<tr>
<td>Homemaker</td>
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<td>14.30</td>
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<tr>
<td>Unemployed</td>
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all three treatment groups (PT1, PT2, and NP). Group one had nine different therapists, group two had eight different therapists, and group three had eight different therapists. Three therapists had cases from all three groups, seven therapists had cases from two different groups, and two therapists had cases from one group. Therapist variables were not examined.

Instruments

The *Family Assessment Device* (FAD; Epstein, Baldwin, & Bishop, 1983) is a client self-report measure that assesses family functioning on six subscales and a global functioning scale. The responses are recorded on 4-point Likert-type scales with answers ranging from 1 = *Strongly Agree* to 4 = *Strongly Disagree*. Problem resolution (Weakland et al., 1974), communication (Segal & Kahn, 1986), and behaviors (Berg & Miller, 1992) are important in solution-oriented brief therapy; therefore, the Problem Solving, Communication, and Behavior Control subscales of the FAD were used in this study. The Problem Solving scale contains questions such as, "We usually act on our decisions regarding problems." The Communication scale contains
questions such as, "When someone is upset the others know why." The Behavior Control scale contains questions such as, "You can easily get away with breaking the rules" (Appendix A contains all forms, instructions, and instruments given to participants; Appendix B contains employed subscales of the FAD). Test-retest reliability estimates at one-week intervals for the three subscales are reported by the authors of the scale as follows: Problem Solving ($r = .66; 5$ items), Communication ($r = .72; 6$ items), and Behavior Control ($r = .73; 9$ items) (Miller, Epstein, Bishop, & Keitner, 1985). The authors report reliability, (Cronbach's alpha) for each scale as Problem Solving ($\alpha = .74; 5$ items), Communication ($\alpha = .75; 6$ items), and Behavior Control ($\alpha = .72; 9$ items). Reliability varies from $\alpha = .67$ to $\alpha = .76$ for the other FAD subscales (Epstein et al., 1983). The authors report that concurrent validity of the FAD has been established by obtaining results consistent with the FAD scales and other family measures (FACES II; Olsen, Bell, & Porter, 1982; Family Unit Inventory, Van der Veen, Howard, & Austria, 1970).
The Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) is an eight-item self-report, paper-and-pencil measure that assesses customer satisfaction with mental health services. Responses are recorded on a Likert-type scale with scores ranging from 1 to 4 with higher scores representing greater satisfaction. Internal consistency is reported to range from $\alpha = .84$ to $\alpha = .93$. The CSQ correlates with the 18-item version of the Client Satisfaction Questionnaire ($r = .93$; Attkisson & Zwick, 1983) and with the Satisfaction, Helpfulness, Accessibility, Respect, and Partnership scale (SHARP-V; $r = .71$; Perreault, Leichner, Sabourin, & Gendreau, 1993).

The Scaling Question (Berg & Miller, 1992) is a solution-oriented therapy technique that can be used as both assessment and intervention. In this study, the Scaling Question was employed as a client self-report measure of progress that clients have made toward their goals. The scaling question was asked as follows:

Let's say, 10 means how you want your life to be when you solved the problem that brought you here, and 0 means how bad things were when you picked up the phone to set up an appointment, where would you say the problem is at today between 0 and 10? (Berg & Miller, 1992, p. 83)
Responses range on a scale of 0 to 10, where 10 represents clients' having completed their therapeutic goals and 0 represents their situation at the time the phone call was made requesting therapy. Reliability and validity have not been established.

The Global Assessment of Relationship Functioning (GARF; American Psychiatric Association, 1994) is a scale found in the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV; American Psychiatric Association, 1994). The GARF scale is a therapist report of how the marriage, family, or individual relationships are functioning. The GARF scale is divided into five scoring groups with specific criteria that must be met in determining the score. Scores on this scale range from 1 to 100 with higher scores representing better relationship functioning. Scores ranging from 80 to 100 represent relationships that are reported and observed to be functioning well. Scores ranging from 61 to 80 represent relationships that are somewhat unsatisfactory. Scores ranging from 41 to 60 represent relationships that are occasionally satisfying but are dysfunctional or unsatisfying most of the time. Scores from 21 to 40
represent relationships that are seriously dysfunctional and have rare occurrences of relating satisfactorily. Scores ranging from 1 to 20 represent relationships that are so dysfunctional that continued contact and attachment are difficult. To obtain consistency between therapists, a computer scoring program was employed (Dennis, 1994). The computer program required the therapists to answer 30 multiple choice questions about the clients' relationship (Appendix C contains the questions asked by the computer program). The computer then computed the GARF score.

Reliability and validity have not been established.

The pretreatment change questions employed by Weiner-Davis et al. (1987) are as follows:

Our agency is involved in a research project and we would like to have you answer the following questions before we begin therapy.

1. Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed about your situation?

2. (If yes to #1): Do these changes relate to the reason you came for therapy?

3. (If yes to #1): Are these the kinds of changes you would like to continue to have happen?

(p. 360)
Some have suggested that the format of the first question suggests that pretreatment changes are the rule rather than the exception and that clients are influenced to report higher incidence of pretreatment change (Allgood et al., 1994; Lawson, 1994). The literature suggests that change is a continuous process (de Shazer, 1989; Kral & Kowalski, 1989) and as part of that process people will experience a pretreatment change, making it the rule and not the exception. Therefore, a format similar to Weiner-Davis et al. that suggests that change took place was employed. The pretreatment change questions were changed to read more easily and were presented on paper as follows:

Our agency is involved in a research project and we would like to have you answer the following questions before we begin therapy.

1. Between the time they make the appointment for therapy and the first session, many times people notice that things already seem different. What have you noticed about your situation?

2. (If responded to #1): Do these changes relate to the reason you came for therapy?

3. (If responded to #1): Are these the kinds of changes you would like to continue to have happen?

Procedures

After receiving approval from the Institutional Review Board (see Appendix D for approval form), all families,
couples, and individuals who requested therapy at the U.S.U. Marriage and Family Therapy Clinic were asked by the researcher to participate in the study by signing a consent form, filling out the FAD (Epstein et al., 1983), answering the pretreatment change questions (Weiner-Davis et al., 1987), responding to the Scaling Question (Berg & Miller, 1992), and filling out a demographics questionnaire (Appendix E contains forms employed by the researcher and therapist to record information). The consent form informed the clients that confidentiality would be maintained and failure to consent would not jeopardize treatment, their relationship with the University, or their relationship with the Marriage and Family Therapy Clinic. One client declined participation in the study. At the end of the first session, therapists recorded a GARF score (American Psychiatric Association, 1994) on the therapist report form.

This study examined the relationship between (a) noticing pretreatment change and (b) therapeutic outcome. Due to the fact that pretreatment changes occurred prior to therapy and prior to participation in the research, complete random assignment into groups was not possible. Therefore, based on responses to the pretreatment change questions and
a coin flip, cases were assigned to one of three groups: Group one (PT1; n = 10) consisted of cases who reported at least one pretreatment change they wished to continue and the pretreatment change was noticed by the therapist in sessions one through six; group two (PT2; n = 10) consisted of cases who reported at least one pretreatment change they wished to continue and had their pretreatment change noticed in sessions four through six (inclusion into group PT1 or PT2 was determined by a coin flip); group three (NP; n = 19) consisted of cases who reported no pretreatment change or answered "no" to question three of the pretreatment change questions. The NP group was included as a comparison group to examine the effects of how noticing (PT1) or not noticing (PT2) pretreatment change varied from cases that did not report pretreatment changes (NP) but still participated in therapy. Due to the lack of possible random assignment for cases that reported pretreatment change and cases that did not, the equivalence or difference of the groups at intake employing a t-test was employed (Kazdin, 1992; See research question one on page 36 and Table 10). Subjects in these three groups were examined in this study.
Cases reporting at least one pretreatment change they wished to continue were randomly assigned by the researcher to PT1 or PT2 by a coin flip, with the exception of the last case, which was assigned to PT2. The pretreatment changes were read by the researcher to ensure that noticing or ignoring the reported pretreatment changes would not cause harm to the clients. Cases not reporting a pretreatment change or answering "no" to question three above were placed in the NP group. The therapists for PT1 were informed of the pretreatment change and instructed to notice that change in sessions one through six or until the case reached their goals by asking, "How is doing [pretreatment change] going?" Therapists were instructed to listen to the response, but not explore the pretreatment change further; otherwise, therapists conducted therapy as usual. As part of the assigned therapeutic homework for each session, cases in PT1 were asked to continue their pretreatment change.

PT2 had therapy conducted as usual; the therapists were not informed of the cases' pretreatment changes and continued therapy as usual for three sessions; they were asked to not ask about, notice, or explore pretreatment
changes. The NP group also had therapy conducted as usual. For a summary of procedures, see Table 2.

The therapist report form was given to therapists to remind them of the change they were asked to notice (groups PT1, PT2), and the GARF score they were asked to compute (groups PT1, PT2, and NP).

After three sessions, the researcher again administered the FAD (Epstein et al., 1983) and CSQ (Larsen et al., 1979), and asked the Scaling Question (Berg & Miller, 1992) in all three groups. Also, the researcher asked all cases in PT1 and PT2 if their pretreatment change was still present. This required a simple yes or no answer and was recorded on the researcher report form. At the end of three sessions, therapists computed and recorded a second GARF score (American Psychiatric Association, 1994) for cases in all three groups.

At the end of three sessions, the therapists for PT2 were informed of the pretreatment change that was recorded earlier. These therapists then noticed the pretreatment change each session by asking, "How is doing [pretreatment change] going?" and the pretreatment change was assigned as part of the homework. No other changes were made in the
Table 2
Noticing Pretreatment Change Procedures

<table>
<thead>
<tr>
<th></th>
<th>PT1</th>
<th>PT2</th>
<th>NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>How is doing [pretreat] going? and assigned as homework ses. 1-3</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>How is doing [pretreat] going? and assigned as homework ses. 4-6</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

therapy process for PT1 and NP groups; therapists continued treatment.

Therapy continued for three more sessions (six total) or until the cases reached their goals, whichever came first. After three more sessions, or when the cases reached their goals and terminated therapy, the researcher asked the Scaling Question (Berg & Miller, 1992) and administered the FAD (Epstein et al., 1983) and the CSQ (Larsen et al., 1979); all cases in PT1 and PT2 were asked if their
pretreatment changes were still present by the researcher; therapists recorded a GARF score (American Psychiatric Association, 1994) for cases in all groups. The number of sessions attended by dropouts (i.e., cases who terminated therapy without reaching their goals) was recorded on the researcher report form (see Table 3).

At the end of the study, clients requesting information about the purpose of the study were given a brief description of the study. No clients requested information about the study.

Research Questions

The procedures above were used to collect data in answering the following research question.

1. What are the differences between cases that report a pretreatment change and cases that do not on self-report (Scaling Question scores—a measure of clients' progress toward goals; and Problem Solving, Communication, and Behavior Control subscales of the FAD) and therapist report measures (GARF) at intake?
Table 3

**Instrument Administration Schedule**

<table>
<thead>
<tr>
<th></th>
<th>PT1</th>
<th>PT2</th>
<th>NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
<td>FAD, GARF,</td>
<td>FAD, GARF,</td>
<td>FAD, GARF,</td>
</tr>
<tr>
<td></td>
<td>Scaling</td>
<td>Scaling</td>
<td>Scaling</td>
</tr>
<tr>
<td></td>
<td>question</td>
<td>Question</td>
<td>Question</td>
</tr>
<tr>
<td>After 3rd</td>
<td>FAD, GARF,</td>
<td>FAD, GARF,</td>
<td>FAD, GARF,</td>
</tr>
<tr>
<td>Session</td>
<td>Scaling</td>
<td>Scaling</td>
<td>Scaling</td>
</tr>
<tr>
<td></td>
<td>Question,</td>
<td>Question,</td>
<td>Question,</td>
</tr>
<tr>
<td></td>
<td>CSQ, Is</td>
<td>CSQ, Is</td>
<td>CSQ</td>
</tr>
<tr>
<td></td>
<td>change</td>
<td>change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>present</td>
<td>present</td>
<td></td>
</tr>
<tr>
<td>After 6th</td>
<td>FAD, GARF,</td>
<td>FAD, GARF,</td>
<td>FAD, GARF,</td>
</tr>
<tr>
<td>session or</td>
<td>Scaling</td>
<td>Scaling</td>
<td>Scaling</td>
</tr>
<tr>
<td>termination</td>
<td>Question,</td>
<td>Question,</td>
<td>Question,</td>
</tr>
<tr>
<td></td>
<td>CSQ, Is</td>
<td>CSQ, Is</td>
<td>CSQ</td>
</tr>
<tr>
<td></td>
<td>change</td>
<td>change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>present</td>
<td>present</td>
<td></td>
</tr>
</tbody>
</table>

2. What is the percentage of cases for each group (PT1, PT2, and NP) that increase on (a) Global Assessment of Relationship Functioning scores; (b) Scaling Question scores (a measure of client's progress toward goals); (c) Problem Solving, Communication, and Behavior Control subscales scores of the FAD after session three and after session six or termination?
3. For groups that report pretreatment change, what is the difference between noticing pretreatment change and case ratings of satisfaction with therapeutic services after session three and session six?

4. Does noticing pretreatment changes that clients wish to continue keep those changes from disappearing over a period of three sessions?
RESULTS

This study examined claims that pretreatment changes are beneficial to therapeutic outcome by exploring the relationship between (a) noticing pretreatment changes as an intervention and (b) therapeutic outcome in the areas of relationship functioning, goal attainment, problem solving, communication, and behavior control.

As with many longitudinal studies, attrition in this study was notable: 51% (see Table 4). It is not uncommon for many people to drop out of therapy (Anderson, Atilano, Bergen, Russell, & Jurich, 1985; Lowman et al., 1984; Talman, 1990). The dropout rate for this study was not unusual. Also, it is also not uncommon for therapy to be completed in fewer than six sessions (Talmon, 1990). In this study, 12 cases reached their goals before the sixth session. Due to the high dropout rates, and cases that reached their goals before six sessions, data from session six were dropped from the analysis and the data from intake and the end of session three were analyzed.
A secondary factor analysis using a varimax rotation was employed on the subscales of the FAD (Epstein et al., 1983) to determine if using the Problem Solving, Communication, and Behavior Control subscales was appropriate. The analysis extracted two factors that account for 69.87% of the variance. The two factors are the Problem Solving and Communication subscales of the FAD. This factor analysis is for the current study only (see Table 5). Because the Behavior Control subscale can largely be accounted for by the other two subscales, the Behavior Control subscale was not included in the analyses.
Table 5

Factor Matrix for Problem Solving and Communication

<table>
<thead>
<tr>
<th>Variable</th>
<th>Factor I</th>
<th>Factor II</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Functioning</td>
<td>0.88</td>
<td>0.06</td>
</tr>
<tr>
<td>Affective Involvement</td>
<td>0.83</td>
<td>0.18</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>0.82</td>
<td>-0.05</td>
</tr>
<tr>
<td>Communication</td>
<td>0.81</td>
<td>0.10</td>
</tr>
<tr>
<td>Roles</td>
<td>0.69</td>
<td>-0.12</td>
</tr>
<tr>
<td>Behavior Control</td>
<td>0.68</td>
<td>0.40</td>
</tr>
<tr>
<td>Affective Responsiveness</td>
<td>-0.00</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Note. Variance explained = 69.87%

Reliability for the FAD (Epstein et al., 1983) was also computed. The results revealed $\alpha = .82$ and a corrected item-total correlation for each of the employed sub-scales of Problem Solving ($r = .66$) and Communication ($r = .69$).

Factor analysis and reliability were calculated on the CSQ (Larsen et al., 1979). Factor analysis revealed that
Table 6

$\chi^2$ Values for Demographic Variables Between Dropouts and Non-dropouts

<table>
<thead>
<tr>
<th>Variable</th>
<th>$\chi^2$</th>
<th>df</th>
<th>$N$</th>
<th>$p$</th>
<th>$\phi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.24</td>
<td>1</td>
<td>61</td>
<td>0.62</td>
<td>0.01</td>
</tr>
<tr>
<td>Education</td>
<td>0.13</td>
<td>1</td>
<td>61</td>
<td>0.72</td>
<td>0.00</td>
</tr>
<tr>
<td>Degree</td>
<td>0.01</td>
<td>1</td>
<td>61</td>
<td>0.99</td>
<td>0.00</td>
</tr>
<tr>
<td>Income</td>
<td>0.11</td>
<td>2</td>
<td>54</td>
<td>0.95</td>
<td>0.00</td>
</tr>
</tbody>
</table>

The measure has one factor. Reliability was $\alpha = 0.85$. Both the FAD and the CSQ had reliability similar to that reported in the literature.

The advantage of pretest allowed for the evaluation of subjects lost by comparing them with subjects that remained in the study (Kazdin, 1994). Chi-square ($\chi^2$) analysis of the sample revealed that there was no bias across demographic variables for clients who dropped out of the study and those who completed the study. Results of $\chi^2$ tests are found in Table 6 and are based on frequencies found in Table 1. $\chi^2$ values were obtained after some categories were collapsed to fulfill the requirements of the test: Education was collapsed to "attended high school" and
"attended post high school"; Degree earned was collapsed to "high school diploma" and "post high school degree"; and Income was collapsed to "$0 to $5,000", "$5,000 to $15,000", and "over $15,000". $\chi^2$s were not computed for race or occupation due to the sample being mainly Caucasian and the large number of categories in the occupation variable.

The comparison of cases that dropped out of the study and cases that remained in the study was also examined across dependent variables employing $t$ test analyses (Miller & Wright, 1996). The $t$ tests revealed that there was no bias in the sample between cases who dropped out of the study and those who remained in the study across the dependent variables of Relationship Functioning $t(35) = -0.05, p = 0.96$; Scaling Question scores (goal attainment) $t(35) = 0.71, p = 0.48$; Problem Solving $t(35) = 0.72, p = 0.47$; and Communication $t(35) = 0.62, p = 0.54$. Means and standard deviations are found in Table 7.

The means and standard deviations for the dependent variables across groups (PT1, PT2, and NP) for intake and after session three are found in Table 8.

Correlations revealed that while the Problem Solving and Communication subscales were positively correlated, no
### Table 7

**Means and Standard Deviations of Cases that Dropped Out and Remained in the Study**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Remained</th>
<th>Dropped Out</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>GARF Scores</td>
<td>56.14</td>
<td>13.96</td>
</tr>
<tr>
<td>Scaling Scores</td>
<td>3.29</td>
<td>2.05</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>2.39</td>
<td>0.33</td>
</tr>
<tr>
<td>Communication</td>
<td>2.47</td>
<td>0.41</td>
</tr>
</tbody>
</table>

Other continuous variables were highly correlated (see Table 9). Due to the fact that communication is required to problem solve, the two FAD subscales were expected to be correlated. It can be assumed that the other continuous variables are measuring unique constructs.

**Research Question One**

1. What are the differences between cases that report a pretreatment change (groups PT1 and PT2) and cases that do not (group NP) on self-report (Scaling Question scores, and
Problem Solving and Communication subscales of the FAD) and therapist report measures (GARF) at intake?

Table 8

Means and Standard Deviations of Dependent Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>PT1 M</th>
<th>PT1 SD</th>
<th>PT2 M</th>
<th>PT2 SD</th>
<th>NP M</th>
<th>NP SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GARF scores</td>
<td>58.10</td>
<td>17.59</td>
<td>56.40</td>
<td>13.87</td>
<td>56.42</td>
<td>14.43</td>
</tr>
<tr>
<td>Scaling scores</td>
<td>3.85</td>
<td>2.29</td>
<td>2.80</td>
<td>2.47</td>
<td>2.28</td>
<td>2.11</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>2.38</td>
<td>0.36</td>
<td>2.42</td>
<td>0.25</td>
<td>2.30</td>
<td>0.41</td>
</tr>
<tr>
<td>Communication</td>
<td>2.48</td>
<td>0.25</td>
<td>2.51</td>
<td>0.29</td>
<td>2.34</td>
<td>0.47</td>
</tr>
<tr>
<td><strong>After Session Three</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GARF scores</td>
<td>67.44</td>
<td>14.90</td>
<td>60.60</td>
<td>12.97</td>
<td>66.45</td>
<td>14.06</td>
</tr>
<tr>
<td>Scaling scores</td>
<td>4.89</td>
<td>1.98</td>
<td>4.60</td>
<td>2.63</td>
<td>4.75</td>
<td>2.28</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>2.30</td>
<td>0.34</td>
<td>2.28</td>
<td>0.31</td>
<td>2.13</td>
<td>0.37</td>
</tr>
<tr>
<td>Communication</td>
<td>2.31</td>
<td>0.27</td>
<td>2.42</td>
<td>0.24</td>
<td>2.10</td>
<td>0.45</td>
</tr>
</tbody>
</table>
Table 9

**Correlation Coefficients for Dependent Variables at Intake**

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PS</td>
<td>--</td>
<td>0.64**</td>
<td>-0.08</td>
<td>-0.03</td>
<td>0.02</td>
</tr>
<tr>
<td>2. C</td>
<td>--</td>
<td>-0.05</td>
<td>-0.14</td>
<td>0.18</td>
<td></td>
</tr>
<tr>
<td>3. Scale</td>
<td>--</td>
<td>-0.16</td>
<td>0.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. GAF</td>
<td>--</td>
<td></td>
<td>-0.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. CSQ</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PS = Problem Solving, C = Communication, Scale = Scaling Questionnaire, GAF = Global Assessment of Relationship Functioning, CSQ = Client Satisfaction Questionnaire.

** p ≤ .01

Due to the fact that this question explores a variable that took place prior to participation in the study randomization was not possible. These variables can be the focus of study, however (Kazdin, 1992). T tests were employed because they are less sensitive to departures from normality (SPSS, Inc., 1990). The t tests revealed that there were no statistically significant differences between cases that
reported pretreatment change (groups PT1 and PT2) and cases that reported no pretreatment change (group NP) on Problem Solving, Communication, and Scaling Question scores, and Global Assessment of Relationship Functioning at intake. See Table 10. Hence, the procedures for assigning cases to groups was effective in reducing differences prior to therapy.

Research Question Two

2. What is the percentage of cases in each group (PT1, PT2, and NP) that increase on (a) Global Assessment of Relationship Functioning scores; (b) Scaling Question scores; and (c) Problem Solving and Communication subscales scores of the FAD after three sessions? The cases from each group were examined individually for increase on each of the dependent variables. The percentage of cases that changed for each group was computed. Group NP had the highest percent of cases that increased Relationship Functioning and Scaling Question scores. Group PT1 had the highest percentage of cases that increased Problem Solving scores. Group PT2 had the highest percent of cases that increased Communication scores. See Table 11. The overall
percentage of cases that increased Problem Solving and Communication scores was low.

Table 10

**Group T Tests Between Cases Reporting Pretreatment Change and Cases Not Reporting Pretreatment Change for Problem Solving, Communication, Scaling Scores, and GARF Scores**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group 1* (n=20)</th>
<th>Group 2** (n=19)</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>t</td>
<td>p</td>
</tr>
<tr>
<td>GARF</td>
<td>57.28</td>
<td>15.44</td>
<td>56.42</td>
<td>14.43</td>
<td>0.17</td>
<td>0.86</td>
</tr>
<tr>
<td>Scaling Question</td>
<td>3.33</td>
<td>2.38</td>
<td>2.28</td>
<td>2.12</td>
<td>1.45</td>
<td>0.16</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>2.40</td>
<td>0.30</td>
<td>2.29</td>
<td>0.41</td>
<td>0.88</td>
<td>0.39</td>
</tr>
<tr>
<td>Communication</td>
<td>2.50</td>
<td>0.26</td>
<td>2.34</td>
<td>0.47</td>
<td>1.29</td>
<td>0.21</td>
</tr>
</tbody>
</table>

*Group 1: reported pretreatment change (combined groups PT1 and PT2).

**Group 2: reported no pretreatment change (NP group).

Note. Group 1: reported pretreatment change; Group 2: reported no pretreatment change. df = 37.
Table 11

Percent of Cases that Increased Across Dependent Variables and Groups PT1, PT2, and NP Between Intake and Session Three

<table>
<thead>
<tr>
<th>Variables</th>
<th>PT1</th>
<th>PT2</th>
<th>NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Functioning</td>
<td>67</td>
<td>80</td>
<td>82</td>
</tr>
<tr>
<td>Scaling Question</td>
<td>67</td>
<td>60</td>
<td>73</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>33</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Communication</td>
<td>22</td>
<td>40</td>
<td>9</td>
</tr>
</tbody>
</table>

Research Question Three

3. For groups that reported pretreatment change, what is the difference between noticing pretreatment change and case ratings of satisfaction with therapeutic services after three sessions?

This question also focuses on the variable of pretreatment change that occurred before participation in the study limiting the possibility of true randomization. However, it can be the focus of research (Kazdin, 1992). A Kruskal-
Wallis analysis of variance was employed to analyze the case satisfaction scores. The Kruskal-Wallis was employed for two reasons: a) Due to the high dropout rate, the size of the groups was small (see Table 4); b) the data were suspected to depart from normality. Gibbons (1993) recommends employing nonparametric statistics for either of the reasons above. Also, the Kruskal-Wallis compares mean ranks and is less likely to find erroneous results with small samples that depart from normality (SPSS, Inc., 1990).

No statistically significant differences between groups for client satisfaction after the third session were found $H(2) = 0.01, p = 0.99$.

Research Question Four

4. Does noticing pretreatment changes that clients wish to continue keep those changes from disappearing over a period of three sessions?

Of the 19 clients who completed three sessions of therapy and reported a pretreatment change, 15 (79%) of them continued reported pretreatment changes. Of the 13 clients in PT1 who had pretreatment changes noticed, 9 (69%) continued those changes after three sessions. There were 6
clients in PT2, who did report those pretreatment changes noticed, but all 6 (100%) reported continuing their reported pretreatment changes after three sessions.
DISCUSSION

This study examined claims that pretreatment changes are beneficial to therapeutic outcome by exploring the relationship between (a) noticing pretreatment changes as an intervention and (b) therapeutic outcome in the areas of Relationship Functioning, Goal Attainment, Problem Solving, and Communication. The brief/solutions family therapy orientation claims that therapists who practice brief/solutions concepts will have clients who reach their goals faster and report greater satisfaction with the services they receive (Miller, 1994). However, there is little empirical support for these claims. This research explored the brief/solutions concept of pretreatment changes and the effects of noticing desirable pretreatment changes on therapeutic outcome. The outcome variables of Relationship Functioning, Progress Toward Goals, Problem Solving, and Communication were employed because of their importance to family therapy and to the brief/solutions orientation of family therapy.

Summary of Results

The results of exploring the relationship between
noticing pretreatment changes and therapeutic outcome showed many things about pretreatment changes. First, the percentage of clients reporting pretreatment change was 53% of the sample, less than the 67% previously reported (Weiner-Davis et al., 1987). The percentage for this study was even lower than the 62.20% reported by Lawson (1994). The sample in this study is similar to the Lawson (1994) study in that participants were seen at a university marriage and family therapy clinic and were predominately lower socioeconomic status and had similar presenting problems. Differences in demographics were not likely to contribute to reduced reporting of pretreatment changes. No demographics were reported in the Weiner-Davis et al. 1987 study, so a comparison cannot be made. However, the pretreatment change questions were asked in written form and the clients were left alone to decide if they had experienced a pretreatment change. In other studies, the pretreatment questions were asked by the therapist, which may account for the difference in percentage of participants reporting pretreatment change.

Clients who reported pretreatment change and clients who did not report pretreatment change were not
statistically different in relationship functioning, goal attainment, problem solving, or communication at intake. Even though some cases have made changes before therapy, these cases are not significantly different from cases who have not made changes on the variables measured in this study.

The group that did not report pretreatment change had a higher percentage of cases that improved on Global Assessment of Relationship Functioning and Scaling Question scores. While the percentages were lower, the group that noticed pretreatment change for three sessions had a higher percentage of cases increase their Problem Solving scores, and the group that did not notice a pretreatment change had a higher percentage of cases increase their Communication scores. This provides limited support for reporting that pretreatment changes at intake or noticing pretreatment changes influences therapeutic outcome for the variables measured.

There were no differences in case ratings of satisfaction with therapeutic services between cases who had pretreatment changes noticed, cases who did not have pretreatment changes noticed, or cases who did not report a
pretreatment change.

The pretreatment changes reported by clients did not disappear when they were not noticed. In fact, an overwhelming percentage reported that those changes continued in some cases without being noticed by the therapist (clients in PT2). All participants who reported a pretreatment change had that change noticed by filling out the pretreatment change questions. It is possible that simply asking about pretreatment changes is enough to keep them from disappearing.

Discussion of Results

This research added to the literature that pretreatment changes are a part of the lives of many clients. Although the percentage of clients reporting pretreatment change in this study was lower than previous studies, half of clients reported desirable pretreatment changes. Once noticed, these changes did not seem to disappear. However, further research is necessary to understand how to apply these changes beneficially in therapy.

This research has implications for the field of family therapy. First, this research adds to research on the
effectiveness of family therapy. Paired t tests revealed that cases from all three groups improved significantly on the variables of Relationship Functioning $t(24) = -3.97, p < 0.01, ES = 0.49$ and Scaling Question scores $t(23) = -3.36, p < 0.01, ES = 0.83$. See Table 12. Second, questions about the usefulness of employing pretreatment changes as an intervention in therapy were raised. Second, therapists need to be cautious about using interventions that have not been empirically tested. Further research is necessary to understand how, or if, pretreatment changes can be employed usefully in therapy.

Table 12

**Means and Standard Deviations for Relationship Functioning and Scaling Question Scores at Intake and After Three Sessions**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Intake</th>
<th></th>
<th>After 3 Sessions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>GARF Scores</td>
<td>58.80</td>
<td>14.32</td>
<td>65.64</td>
<td>13.18</td>
</tr>
<tr>
<td>Scaling Scores</td>
<td>2.98</td>
<td>2.31</td>
<td>4.77</td>
<td>2.15</td>
</tr>
</tbody>
</table>

$N = 25$
Limitations

Limitations of this study include the sampling strategy, attrition rate, experimental confound, diffusion of treatment, pretest sensitization, and low statistical power. The sampling strategy for assigning cases to therapists had to be put in place while maintaining the procedures of the U.S.U. Marriage and Family Therapy Clinic. Due to this constraint, unexperienced therapists who were occupied with learning the therapeutic process were asked to do one more thing: notice pretreatment change. This possibly limited the effectiveness of the intervention. In addition, to increase the sample size, the number of participating therapists had to be larger, possibly limiting the effectiveness and control of the intervention. Also, due to all the therapists being trained in similar models of therapy, therapy as usual for clients in PT2 and NP may have been more similar than different from PT1, washing out the effects of noticing pretreatment change.

Attrition was a problem; clients were examined across demographic variables and cases were examined across dependent variables to see if there were differences between cases that dropped out of therapy and cases that remained in
the study. No biases were found, but the dropout rate by the second assessment time was high, reducing the sample size of each group and making analysis difficult, thus limiting generalizability.

The potential for multiple therapists to treat cases in the same group differently exists, introducing a potential experimental confound. By assigning cases from each group to each therapist, a diffusion of treatment across groups may have been the result, washing out the effects of noticing pretreatment change. Therapists may have treated a case from PT1 as if it were from NP, failing to notice the pretreatment change and not assigning the pretreatment change as homework. For group PT1, therapists noticed pretreatment changes 65% of the time. Clearly, intervention adherence was a problem.

The FAD was given before therapy began and was given up to three times during the course of treatment. This may have created pretest sensitization, reducing the ability of the FAD to measure the employed constructs.

Finally, the small sample size with a high dropout rate caused a reduction in statistical power. This reduction of
power alone could account for no differences between groups and eliminates the generalizability of the results.

Future Research

Future research should limit the number of therapists participating in the study to allow for greater control of the independent variable. Also, the level of training the therapists have experienced should be greater than in this study to allow therapists to notice pretreatment change and not significantly increase their tasks in therapy.

Future research should include a larger sample size to buffer a potentially high dropout rate. Exploring the relationship between noticing pretreatment changes and therapeutic outcome could include other constructs to further understand pretreatment changes. Ideas include events preceding pretreatment changes, constructs that may predict that a pretreatment change would occur, the relationship between the chronicity of the problem and pretreatment change, and the number of days between the initial phone contact and first session. Other contextual variables, such as stressors, family configuration, and
social support system, may impact the occurrence of pretreatment changes.

Particular presenting problems and their relationship to pretreatment changes should also be explored. Presenting problems may have an influence on the occurrence of pretreatment changes. Also, different presenting problems may benefit more from noticing pretreatment changes as an intervention.

Miller (1994) hypothesized that the reason solutions-oriented brief therapy is popular is not because the clients make progress more quickly, or because they are more satisfied with the services they receive, but rather because therapists feel better about what they are doing when employing this model of therapy. Differences may exist among the therapists who like and use a particular model in the way they think, but not necessarily in what they do. The therapists in this study used a portion of this model because they were instructed to do so and not because it was their preferred way of doing therapy. Therefore, therapist variables could be included in the research, for example, therapist experience level, training, and therapist
satisfaction with performing therapy or with the brief/solutions model.

This information would further the knowledge about the usefulness of noticing pretreatment changes in therapy. Future research is needed to understand how to employ pretreatment changes as an intervention and the impact those changes can have on therapeutic outcome.

Conclusion

Even though this research did not empirically substantiate claims about solution-oriented brief therapy and pretreatment changes that are suggested in the literature, it did substantiate the effectiveness of family therapy and the existence of pretreatment changes. Further research is needed to understand more about how solution-oriented brief therapy works (and for whom), how it is best used as a therapeutic model, and which components are most important for influencing positive outcome in therapy.
REFERENCES


APPENDICES
Appendix A

All Forms Given to Clients
I understand that the Utah State University Marriage and Family Therapy Clinic is currently conducting a research project on therapeutic techniques in therapy. I understand that by participating in this research I will be asked to fill out questionnaires and answer questions about therapy. These questionnaires and questions will be asked up to three times.

I understand that my participation in this study will aid in the understanding of the therapy process, and make therapy more beneficial for clients.

I understand that the risks associated with this study are risks normally associated with receiving therapy. I may at times be asked to discuss relationship, psychological, and/or emotional issues that may at times be distressing. However, I understand that this process is intended to help me personally and with my relationships.

I understand that my deciding not to consent to participate in this research project will not have a negative effect on my receiving therapy, my relationship with Utah State University, or my therapist. I also understand that at any time during the project I have the right to stop further participation, which will have no negative effects on my therapy.

I understand that all test scores and answers to questions will be kept confidential and will not contain my name or other identifying information but will be used in the pool of research data for this project. Also, if I have any questions about the research project they will be answered.

I agree to participate in this study.

This form is to be signed by all participating members.

Signed: ___________________________ Date: __________

________________________________________________________

______________________________

Witness: ___________________________

_______ Client ID _______ Subject ID
Instructions

The forms are various questionnaires; please do your best to answer all the questions. There are no right or wrong answers.
Personal Information

1. Male _____ Female _____

2. Age _____

3. Ethnicity/Race
   _____ Hispanic
   _____ Asian
   _____ Afro-American
   _____ Caucasian
   _____ Other (please specify)

4. Place an X next to the category that represents the amount of education you have had the opportunity to receive:
   _____ Less than 12 years
   _____ High school diploma or equivalent
   _____ Less than 2 years after high school
   _____ Greater than 2 years post high school

5. Place an X next to the highest degree you have had the opportunity to receive:
   _____ High School Degree or equivalent
   _____ Associates Degree or equivalent
   _____ Bachelors Degree or equivalent
   _____ Masters Degree or equivalent
   _____ Doctoral Degree or equivalent
6. Place an X next to the description that best represents your current occupation:

- [ ] Professional
- [ ] Managerial (nurse, technician, etc.)
- [ ] Farmer
- [ ] Skilled labor
- [ ] Sales, Clerical
- [ ] General Service
- [ ] Laborer, Waitress
- [ ] Student
- [ ] Unemployed
- [ ] Homemaker

7. How many children do you have? ______

8. Place an X next to the category that best represents your current income:

- [ ] $0 - $5,000
- [ ] $5,000 - $15,000
- [ ] $15,000 - $25,000
- [ ] $25,000 - $35,000
- [ ] Over $35,000
Subject ID____

Our agency is involved in a research project and we would like to have you answer the following questions before we begin therapy.

1. Between the time they make the appointment for therapy and the first session, many times people notice that things already seem different. What have you noticed about your situation?

2. (If responded to #1): Do these changes relate to the reason you came for therapy?

3. (If responded to #1): Are these the kinds of changes you would like to continue to have happen?
Family Assessment Device

This next section contains a number of statements about families. Please read each statement carefully, and decide how well it describes your own family. You should answer as to how you see your family. If you are single, answer these statements in relation to your family-of-origin.

For each statement there are four (4) possible responses:

- Strongly Agree (SA)
- Agree (A)
- Disagree (D)
- Strongly Disagree (SD)

Check SA if you feel that the statement describes your family very accurately.

Check A if you feel that the statement describes your family for the most part.

Check D if you feel that the statement does not describe your family for the most part.

Check SD if you feel that the statement does not describe your family at all.

<table>
<thead>
<tr>
<th>Statement</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Planning family activities is difficult because we misunderstand each other.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. We resolve most everyday problems around the house.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. When someone is upset the others know why.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. When you ask someone to do something, you have to check that they did it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If someone is in trouble, the others become too involved.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. In times of crisis we can turn to each other for support.

7. We don't know what to do when an emergency comes up.

8. We sometimes run out of things that we need.

9. We are reluctant to show our affection for each other.

10. We make sure members meet their family responsibilities.

11. We cannot talk to each other about the sadness we feel.

12. We usually act on our decisions regarding problems.

13. You only get the interest of others when something is important to them.

14. You can't tell how a person is feeling from what they are saying.

15. Family tasks don't get spread around enough.

16. Individuals are accepted for what they are.

17. You can easily get away with breaking the rules.

18. People come right out and say things instead of hinting at them.

19. Some of us just don't respond emotionally.

20. We know what to do in an emergency.
21. We avoid discussing our fears and concerns.  
SA  A  D  SD

22. It is difficult to talk to each other about tender feelings.  
SA  A  D  SD

23. We have trouble meeting our bills.  
SA  A  D  SD

24. After our family tries to solve a problem, we usually discuss whether it worked or not.  
SA  A  D  SD

25. We are too self-centered.  
SA  A  D  SD

26. We can express feelings to each other.  
SA  A  D  SD

27. We have no clear expectations about toilet habits.  
SA  A  D  SD

28. We do not show our love to each other.  
SA  A  D  SD

29. We talk to people directly rather than through go-betweens.  
SA  A  D  SD

30. Each of us has particular duties and responsibilities.  
SA  A  D  SD

31. There are lots of bad feelings in the family.  
SA  A  D  SD

32. We have rules about hitting people.  
SA  A  D  SD

33. We get involved with each other only when something interests us.  
SA  A  D  SD

34. There's little time to explore personal interests.  
SA  A  D  SD

35. We often don't say what we mean.  
SA  A  D  SD
36. We feel accepted for what we are.  
37. We show interest in each other when we can get something out of it personally.  
38. We resolve most emotional upsets that come up.  
39. Tenderness takes second place to other things in our family.  
40. We discuss who is to do household jobs.  
41. Making decisions is a problem for our family.  
42. Our family shows interest in each other only when they can get something out of it.  
43. We are frank with each other.  
44. We don't hold to any rules or standards.  
45. If people are asked to do something, they need reminding.  
46. We are able to make decisions about how to solve problems.  
47. If the rules are broken, we don't know what to expect.  
48. Anything goes in our family.  
49. We express tenderness.  
50. We confront problems involving feelings.
51. We don't get along well together.
52. We don't talk to each other when we are angry.
53. We are generally dissatisfied with the family duties assigned to us.
54. Even though we mean well, we intrude too much into each other's lives.
55. There are rules about dangerous situations.
56. We confide in each other.
57. We cry openly.
58. We don't have reasonable transport.
59. When we don't like what someone has done, we tell them.
60. We try to think of different ways to solve problems.
The Client Satisfaction Questionnaire* (CSQ)

Please help us improve our program by answering some questions about the services you have received at the __________. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

CIRCLE YOUR ANSWER:

1. How would you rate the quality of services you received?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

2. Did you get the kind of service you wanted?

<table>
<thead>
<tr>
<th>No, definitely not</th>
<th>No, not really</th>
<th>Yes, generally</th>
<th>Yes, definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

3. To what extent has our program met your needs?

<table>
<thead>
<tr>
<th>Almost all of my needs have been met</th>
<th>Most of my needs have been met</th>
<th>Only a few of my needs have been met</th>
<th>None of my needs have been met</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

4. If a friend were in need of similar help, would you recommend our program to him/her?

<table>
<thead>
<tr>
<th>No, definitely not</th>
<th>No, I don't think so</th>
<th>Yes, I think so</th>
<th>Yes, definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

5. How satisfied are you with the amount of help you received?

<table>
<thead>
<tr>
<th>Quite dissatisfied</th>
<th>Indifferent or mildly dissatisfied</th>
<th>Mostly satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
6. Have the services you received helped you to deal more effectively with your problems?

<table>
<thead>
<tr>
<th>Yes, they helped a great deal</th>
<th>Yes, they helped somewhat</th>
<th>No, they really didn't help</th>
<th>No, they seemed to make things worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

7. In an overall, general sense, how satisfied are you with the services you received?

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>Mostly satisfied</th>
<th>Indifferent or mildly dissatisfied</th>
<th>Quite dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

8. If you were to seek help again, would you come back to our program?

<table>
<thead>
<tr>
<th>No, definitely not</th>
<th>No, I don't think so</th>
<th>Yes, I think so</th>
<th>Yes, definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

WRITE COMMENTS BELOW:

*(Larsen, Attkisson, Hargreaves, & Nguyen, p. 204, 1979)*
Appendix B

Employed Subscales of the FAD
Employed Subscales of the FAD

Problem Solving

2. We resolve most everyday problems around the house.

12. We usually act on our decisions regarding problems.

24. After our family tries to solve a problem, we usually discuss whether it worked or not.

38. We resolve most emotional upsets that come up.

50. We confront problems involving feelings.

60. We try to think of different ways to solve problems.

Communication

3. When someone is upset the others know why

14. You can't tell how a person is feeling from what they are saying.

18. People come right out and say things instead of hinting at them.

22. It is difficult to talk to each other about tender feelings.

29. We talk to people directly rather than through go betweens.

35. We often don't say what we mean.

43. We are frank with each other.

52. We don't talk to each other when we are angry.

59. When we don't like what someone has done, we tell them.

Behavior Control

7. We don't know what to do when an emergency comes up.

17. You can easily get away with breaking the rules.

20. We know what to do in an emergency.

26. We can express feelings to each other.
32. We have rules about hitting people.
44. We don't hold to any rules or standards.
47. If the rules are broken, we don't know what to expect.
48. Anything goes in our family.
55. There are rules about dangerous situations.
Appendix C

The Global Assessment of Relationship Functioning Scale
The Global Assessment of Relationship Functioning Scale

1. Negotiation (way to solve problems)
The level of problem solving using negotiation.
   1. Problem solving occurs by negotiation
   2. Many problems are negotiated
   3. Some problems are negotiated
   4. Most problems are solved by ordering others
   5. Members try to control each other most of the time.

2. Rules (lack of rules)
Lack of rules combined with loose structure.
   1. Rules come from the family culture
   2. Parental subsystem produces the rules
   3. Some rules and some confusion about acceptable behavior.
   4. Very few rules
   5. Almost no rules

3. Rules (rigid rules)
Overly strict rules inhibit functioning.
   1. Rules come from the family culture
   2. Parental subsystem produces the rules
   3. Some rules and some confusion about acceptable behavior.
   4. Rules are excessively rigid.
   5. Rules are so strict as to prevent the family from functioning.

4. Routines (rigid routines)
Family activity approaches compulsive levels.
   1. Routines are agreed on by all members
   2. Daily routines are present
   3. Daily routines are present but some uncertainty exists
   4. Routines are rigid and do not meet members' needs
   5. Routines are compulsively, ritualistically followed

5. Routines (lack of routines)
Routines establish the limits of family culture. Lack of these routines limits the impact of the culture.
   1. Routines help meet each member's needs
   2. Daily routines are present
   3. Daily routines are present but some uncertainty exists
   4. Routines are ignored, do not meet members' needs
   5. Almost no family routines
6. Adaptation to stress (Developmental changes)
There are normal developmental milestones in the family life cycle. The family can anticipated and adapt to them or they can become problems.

1. Unusual elements and events produce flexible changes
2. Some pain and difficulty in responding to family stress
3. Significant difficulty in adapting to transitional change
4. Life cycle changes generate painful conflicts
5. Developmental changes immobilize the family

7. Adaptation to Stress Unexpected
Crises may occur when unexpected events hit the ability of the family to accommodate to the unexpected.

1. Family stress handled cooperatively
2. Some pain and difficulty in responding to unusual situations
3. Significant difficulty in adapting to family stress
4. Departures and entries generate painful conflict
5. Family stress blocks family function

8. Communication (between members)
Focus on each member to know the physical location of other members.

1. Importance and location of all members in communicating
2. Members are generally aware of each others' activities
3. Members are often aware of other family members' locations
4. Some conflicts about location and action of others
5. Members do not know the location or return and exit events

9. Resolving conflict (interpersonal and multigenerational)
Conflict is part of the family's existence. Conflict can be resolved or it can destroy the family.

1. Conflict resolution by negotiation and communication
2. Some unresolved conflict
3. Conflict interferes with daily routines and communication
4. Problem solving is obviously a frustrating failure
5. Unable to resolve conflict
10. Interpersonal roles (definition of roles)
Members can have functional and acceptable roles. They may also lose themselves for a role of symptom bearer.
1. Roles are understood and are agreed upon
2. Sometimes specific scapegoating
3. Individual needs are often submerged by the partner
4. Excessive scapegoating
5. People treated like objects

11. Boundaries (interpersonal, intrapersonal, extra-personal)
The validity of subsystems and system boundaries.
1. Appropriate tasks are understood and agreed upon
2. There is demarcation between individuals and relationships
3. Sometimes specific subsystems depreciation
4. Boundaries are periodically violated
5. Boundaries cannot be identified or agreed on

12. Coalitions (rigid)
Some coalitions (two or more people joining together against one or more other people) are so rigid they exclude other family members.
1. Each member seems able to form and break relationships
2. Coalitions tend to exist only within subsystems
3. Individual needs often submerge by a coalition
4. Coalitions are rigid
5. Coalitions prevent family functions

13. Coalitions (variable)
Some coalitions (two or more people joining together against one or more other people) are so loose that no one knows which member is aligned with which member.
1. Each member seems able to form and break relationship
2. Coalitions tend to exist only within subsystems
3. Relationships have difficulty being formed
4. Coalitions are confusingly fluid
5. Extended relationships cannot be maintained

14. Distribution of power (abuse of power)
Some people use power to damage others.
1. Recognition of the merit of members
2. Power is usually shared
3. Power is somewhat distributed to all
4. Individual uniqueness is ignored
5. Physical danger, injury, or sexual attack
15. Control of family members
Some members seem to spend all their energy in trying to control other family members.
1. Control comes from the family culture
2. Efforts to control each other is quite often ineffective
3. Control is a major concern
4. Control tends to be only partially effective
5. Control efforts do not appear to work.

16. Responsibility (rigid)
Some family members only allow decisions to be made in selected and regulated ways.
1. Decision making is established for each functional area
2. Decision making is usually competent
3. Excessive rigidity in decision making
4. Decision making is tyrannical
5. Lack of recognized personal responsibilities

17. Responsibility (variable)
Some family members seem unable to make any decisions.
1. Decision making is established for each functional area
2. Decision making is basically effective
3. Significant lack of structure in decision making
4. Decision making is quite ineffective
5. Lack of recognized general responsibilities

18. Feeling tone (anger)
Some families seem to feel angry. They are mad at the world and everything on it.
1. Situationally appropriate family atmosphere
2. Sometimes an atmosphere of irritability
3. Ineffective anger interferes with family enjoyment
4. Open hostility
5. Cynicism is pervasive

19. Feeling tone (depression)
Some families have given up and feel the world is hopeless.
1. Optimistic family atmosphere
2. Sometimes an atmosphere of frustration
3. Pain interferes with family enjoyment
4. Frequent distancing
5. Despair is pervasive
20. Feeling range (excessive)
Some families have so much emotion that they seem like they are going to explode.
1. Wide range of expressed feelings
2. A range of feeling is expressed
3. Some emotional tension present
4. Emotional stress interferes with family enjoyment
5. Behavior unpredictable due to emotional variability

21. Feeling range (not enough)
Families where emotion is oppressed to the point that they seem to be almost dead.
1. Wide range of managed emotions
2. Sometimes emotional blocking present
3. Emotional deadness interferes with family enjoyment
4. Emotional withdrawal impedes functioning
5. Little attention to emotional needs of others

22. Caring (emotional support)
Caring about what happens to others.
1. Atmosphere of caring
2. Considerable caring
3. Some supportive members; unequally distributed
4. Significant unresolved conflict
5. Almost no concern about one another's welfare

23. Warmth (empathy)
Lack of emotional understanding of other members leads to lack of feeling between the members.
1. Atmosphere of warmth
2. Considerable warmth
3. Some warmth; unequally distributed
4. Cool family relations
5. Emotionally sterile culture

24. Involvement (disengagement)
Some families have so little involvement that there seems to be no family.
1. All members are involved with each other
2. Most members actively involved with each other
3. Some members involved with each other
4. Little involvement between the members
5. Almost no involvement in the family
25. Involvement (enmeshment)
Some families are so involved that the family members appear to have no identity as individuals.
1. All members are involved with each other
2. A few areas where members are over involved
3. Some lack of respect for independence
4. Little uniqueness allowed in family
5. Rigid compliance with family roles

26. Attachment (support)
A sense of genuine connection between members.
1. Atmosphere of attachment
2. Considerable level of attachment
3. Some attachment
4. Little attachment
5. Almost no sense of attachment

27. Commitment (duty)
The family's sense that the members will always be members across time.
1. Culture of commitment
2. Considerable commitment to all members
3. Some commitment
4. Little commitment
5. Almost no sense of commitment

28. Sharing of values (culture training)
Families define membership and membership defines beliefs. The expressing and teaching of the family culture.
1. Atmosphere of sharing
2. Considerable sharing
3. Some sharing
4. Little sharing
5. Almost no sharing

29. Respect (treating people like people)
Supporting the humanity in each person.
1. All members display respect to each other
2. Respect is demonstrated most of the time
3. Some areas of disrespect for others
4. Considerable disrespect
5. Little respect for others or self
30. Sexual functioning (adult)
Sexual behavior defines boundaries and subsystem membership.
1. Satisfactory adult sexual relations
2. Adult sexual activity may be reduced or problematic
3. Adult sexual difficulties often present
4. Adult sexual dysfunction is common place
5. Pathological sexual behavior
Appendix D

IRB Approval Form
Researcher Report Form

1. Intake:
   Scaling Question score

2. After three sessions:
   Scaling Question score
   Are you still doing [pretreatment change]? 

3. After six sessions or at termination of therapy:
   Scaling Question score
   Are you still doing [pretreatment change]? 

If terminated number of sessions attended
Appendix E

Researcher and Therapist Report Forms
Subject ID ___

Researcher Report Form

1. Intake:
   Scaling Question score __________

2. After three sessions:
   Scaling Question score __________
   Are you still doing [pretreatment change]? _________

3. After six sessions or at termination of therapy:
   Scaling Question score __________
   Are you still doing [pretreatment change]? _________

   If terminated number of sessions attended __________
Subject ID ____

Therapist Report Form

1. Session one:
   How is doing [pretreatment change] going? _______
   Pretreatment change assigned as homework? _______
   GARF score _______

2. Session two:
   How is doing [pretreatment change] going? _______
   Pretreatment change assigned as homework? _______

3. Session three:
   How is doing [pretreatment change] going? _______
   Pretreatment change assigned as homework? _______
   GARF score _______

4. Session four:
   How is doing [pretreatment change] going? _______
   Pretreatment change assigned as homework? _______

5. Session five:
   How is doing [pretreatment change] going? _______
   Pretreatment change assigned as homework? _______

6. Session six or termination:
   How is doing [pretreatment change] going? _______
   Pretreatment change assigned as homework? _______
   GARF score _______