A Pilot Study of Solution-focused Brief Therapeutic Intervention for Couples

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A PILOT TEST OF A SOLUTION-FOCUSED BRIEF THERAPEUTIC INTERVENTION FOR COUPLES

by

J. Wade Stewart

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development
(Marriage and Family Therapy)

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UTAH STATE UNIVERSITY
Logan, Utah

2011
ABSTRACT

A Pilot Study of Solution-focused Brief Therapeutic Intervention for Couples

by

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Utah State University, 2011

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Department: Family, Consumer, and Human Development

Over the years, many interventions have been used to ameliorate couple distress and increase relationship satisfaction. These interventions have been getting shorter in duration. The purpose of this pilot study was to test the feasibility and impact of a brief intervention using a solution-focused approach (SFBT) for couples. The brief intervention included two two-hour consultations. Data were collected from 30 couples and were analyzed using a repeated measures design. The analyses yielded mixed results. There were statistically significant improvements in the areas of individual well-being and relationship knowledge. There were no significant differences in terms of marital satisfaction, communication skills, and readiness to change, although positive trends were observed in this pilot phase. Implications for future research and development are discussed.

(86 pages)
PUBLIC ABSTRACT

A program was set to provide two 2-hour relationship consultations for couples. The purpose of this program was to attract couples that would not normally seek traditional therapy and/or relationship enrichment programs. The consultations were scheduled a month apart and were designed to be collaborative; the couple offered ideas for behaviors that they wanted to work on. Before the first consultation, each individual filled out several questionnaires about their relationship. In the initial session, the consultant reviewed the results with the couple pointing out the strengths of the couple. In addition, during the initial session, the couple also collaboratively created goals with the consultant. The second consultation was scheduled for a month later to give the couple an opportunity to work on the goals. In the second consultation the couple reviewed progress and restructured their goals. Several measures were used to determine if the program helped couples improve their relationship satisfaction, communication skills, and individual functioning.
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J. Wade Stewart
# CONTENTS

Page

<table>
<thead>
<tr>
<th>ABSTRACT</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUBLIC ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
</tbody>
</table>

## CHAPTER

### INTRODUCTION

#### I. REVIEW OF LITERATURE

- Couple Therapy ................................................................. 7
- Brief Therapy ................................................................. 8
- Brief Couple Interventions ................................................. 9
- Solution-Focused Brief Therapy ......................................... 11
- Relationship Knowledge ................................................... 13
- Communication Skills ..................................................... 14
- Individual Functioning .................................................... 14
- Readiness for Change ....................................................... 15
- Summary ........................................................................... 16
- Research Questions .......................................................... 17

#### II. METHODS .................................................................... 18

- Design .............................................................................. 18
- Participants ..................................................................... 18
- Procedures ...................................................................... 19
- Measures ......................................................................... 23

#### III. RESULTS ................................................................... 27

- Research Question One ................................................... 27
- Research Question Two .................................................... 30

#### IV. DISCUSSION ............................................................... 33

- Research Question One: Impact of the Intervention ............. 33
- Research Question Two: Stage of Change ......................... 37
Limitations ........................................................................................................... 38
Clinical Implications and Conclusion ................................................................. 40

REFERENCES ..................................................................................................... 42

APPENDICES .................................................................................................... 53

Appendix A: Institutional Review Board Approval ............................................. 54
Appendix B: Measure .......................................................................................... 56
Appendix C: Treatment Manual ......................................................................... 61
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sample Characteristics of Males and Females</td>
</tr>
<tr>
<td>2</td>
<td>Characteristics of the Consultants</td>
</tr>
<tr>
<td>3</td>
<td>Marital Quality Pretreatment Versus Posttreatment</td>
</tr>
<tr>
<td>4</td>
<td>Relationship Knowledge Pretreatment Versus Posttreatment</td>
</tr>
<tr>
<td>5</td>
<td>Communication Skills Pretreatment Versus Posttreatment</td>
</tr>
<tr>
<td>6</td>
<td>Individual Functioning Pretreatment Versus Posttreatment</td>
</tr>
<tr>
<td>7</td>
<td>Stages of Relationship Change Pretreatment Versus Posttreatment</td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

Couple distress takes a toll on the physical and mental health of partners and their children. For example, couples in high-conflict relationships are more likely to experience cardiovascular difficulties, alterations in hormones related to stress, and dysregulation of immune function, thereby affecting their overall health (Robles & Kiecolt-Glaser, 2003). Furthermore, repeated patterns of conflict between couples are associated with illnesses including cancer, cardiac disease, and chronic pain (Fincham, 2003). With regard to mental health, a survey of 2,213 Americans found that marital distress was significantly associated with relatively higher levels of anxiety, and mood and substance use disorders (Whisman, 2007). Distress in a relationship has been linked to depression symptoms, eating disorders, and alcoholism (Fincham, 2003). Couple distress has impact on others in the family as well. Couple distress is associated with poor adjustment of children and conflict between siblings (Fincham, 2003).

Couple distress not only affects the couples and children involved, but society at large. For example, problems in marriage are linked to work loss for individuals translating into a total of 6.8 billion dollars a year (Forthofer, Markman, Cox, Stanley, & Kessler, 1996) which might be considerably more by 2011 standards. In the state of Utah, divorce cost approximately 300 million dollars in 2001, including legal fees, divorce filing fees, divorce education classes, housing, and lost productivity (Schramm, 2006). By extrapolating these findings to the United States as a whole, Schramm (2006) estimated the total cost of divorce in the United States to be 33.3 billion dollars annually.
Beyond traditional solutions for marital problems (e.g., close friends, clergy), professional marital therapy has developed over the past several decades to address couple distress (Jacobson & Addis, 1993). Due to the costs to society, some government and community agencies have offered marital education programs in more recent decades in an effort to prevent marital distress and support child well-being (Halford, Markman, & Stanley, 2008). Both therapy and couple education are effective, but each has its limitations. Recent innovations in couple intervention have tried to address these limitations by modifying content and format to better fit couples’ needs. Empirical testing is an important step in the development of such interventions. The purpose of this pilot study was to describe a brief facilitated couple intervention and empirically evaluate its impact.

Couple therapy has been shown to decrease marital distress (Johnson & Lebow, 2000), increase communication skills, and increase relationship satisfaction (Jacobson & Addis, 1993). In addition, couple therapy is effective in treating individual DSM diagnoses (Johnson & Lebow, 2000). Furthermore, individuals who seek help from marriage and family therapy significantly reduced their healthcare utilization (Law & Crane, 2000).

Although there are numerous benefits from couple therapy, there are several aspects that are problematic. Often couples enter therapy “hovering on the tipping point of getting divorced” (Lebow, 2006, p. 175), and thus, couples may not seek therapy when they have relatively lower levels of distress. Therapy can also be very costly; averaging $80 dollars per session (Jayson, 2005), and ranging anywhere from $0 to $300 dollars per
session (Doherty & Simmons, 1996). Some concluded that couples might not seek therapy due to the money and time involved in seeing a therapist (Cordova, Warren, & Gee, 2001). Other barriers exist preventing individuals from seeking psychotherapy including insurance and payment concerns, belief about the inability to find a psychotherapist, knowledge and fear of psychotherapy, and stigmatization (Pepin, Segal, & Coolidge, 2009). Even for couples who are not dissuaded from therapy by these barriers, many couples still drop out of therapy prematurely. For example, in a sample of 140 couple cases, 25.4% of cases dropped out early and 30.1% of all couples did not reach their treatment goals based upon the therapist’s perception (Masi, Miller, & Olson, 2003). Due to these factors, some researchers conclude that marital therapy serves a relatively limited portion of couples from the overall population (Cordova et al., 2001).

Marriage enrichment and marriage education programs are preventative approaches to marital distress and have become increasingly common, particularly during the past two decades. Some have concluded that the field of couple therapy is moving toward more preventative care, rather than only remedial treatments (Deacon & Sprenkle, 2001). Indeed, recent research supports the efficacy of couple education. A meta-analysis of 117 studies showed that couple and relationship education had an effect size on relationship quality ranging from $d = .30$ to $.36$, while the effect sizes on communication skills ranged from $d = .43$ to $.45$ (Hawkins, Blanchard, Baldwin, & Fawcett, 2008).

Although relationship education programs are effective, they have limitations. For example, Lebow pointed out that the typical population that uses these programs is
limited to “heterosexual young people who are substantially satisfied with their relationships” (Lebow, 2006, p. 158). Lebow (2006) further stated that psychoeducation is not effective with relatively more distressed couples who typically seek therapy. Therefore, marital enrichment interventions reach a relatively small proportion of couples from the population (Cordova et al., 2001; Lebow, 2006). Olson, Larson, and Olson-Sigg (2009) outlined several challenges to preventative couples education: (a) marriage education programs are often standardized rather than being tailored for each couple, (b) marriage education usually lacks a preassessment to identify specific issues each couple should resolve, (c) marriage education programs are typically built on a deficit model rather than a strengths model, (d) marriage education is not couple driven, but driven by instructors and facilitators, and (e) marriage programs have difficulty getting couples to attend several sessions because couples have very busy schedules and stressful lives.

Given the diversity of format and foci among couple interventions, an ongoing empirical question is the extent to which interventions can offer effective, relatively brief, client-centered support for couples (Olson et al., 2009). Although the research demonstrates the effectiveness of brief interventions, this study tests how flexible and tailored to the “at-risk” couples a model might be and still be effective. It is also an empirical question as to how brief the intervention can be and still be effective (Cordova et al., 2001).

The purpose of this pilot study was to (a) describe a couple intervention, (b) describe characteristics of couples who attended, and (c) test the intervention’s impact. This pilot study examined the structure and effectiveness of an approach that included
two 2-hour sessions of consultant-like meetings using solution-focused brief therapy (SFBT). The study also examined couple readiness for change, and framed this empirical question in the tenants of the Transtheoretical model (Prochaska & Norcross, 2001). The sessions were referred to as consultations in order to attract couples that might be apprehensive about attending “marriage therapy” or “relationship counseling.”
CHAPTER II
REVIEW OF LITERATURE

In order to contextualize the evaluation of the current couple intervention, this chapter reviews research in the areas of couple therapy and brief therapy and couple education skills training. Couple therapy and marital education programs are addressed to better contextualize the current intervention, which is an intervention with a format that lies somewhere between couple therapy and marital education (Erwin, 2008). This chapter also outlines the theoretical approach used in the current study: solution-focused brief therapy. Variables frequently associated with couple interventions will also be discussed, including relationship quality, relationship knowledge, couple communication, and individual well-being. Readiness to change will also be explored as a contextual factor in this intervention.

The topic of relationship quality has long been of interest to social scientists, and for good reason. Marital status alone has positive impact on familial and individual well-being (Stack & Eshleman, 1998). Marital satisfaction has been found to be relatively more important to personal well-being than factors such as occupational success, religion, housing, and finances combined (Fowers, 2001). Conversely, Gottman (1999) reported that “marital distress, conflict, and disruption are associated with a wide range of deleterious effects on children, including depression, withdrawal, poor social competence, health problems, poor academic performance, a variety of conduct-related difficulties, and markedly decreased longevity” (p. 4).
Due to the association between marital quality and individual well-being (Proulx, Helms, & Buehler, 2007), therapists and family life educators have used various methods to increase relationship quality, including couple therapy, brief couple interventions, and relationship education and skills training. This literature review is by no means comprehensive, but it discusses important themes relative to the current intervention.

**Couple Therapy**

Couple therapy has been shown to help improve problems including couple distress, sexual difficulties, physical aggression, extra-marital affairs, substance use disorders, mood disorders, and anxiety disorders (Snyder, Castellani, & Whisman, 2006). For example, in a meta-analysis, Shadish and colleagues (1993) concluded that 41% of couple treatment conditions were successful in taking couples from a distressed to a non-distressed range in terms of relationship satisfaction (Shadish et al., 1993). A review of several studies on depression and marital satisfaction concluded that “established forms of marital therapy can go far both in improving marital satisfaction and in decreasing depressive symptoms” (Beach, Fincham, & Katz, 1998, p. 656). Subsequent research suggests that this view is accurate: in a review of 20 meta-analyses, Shadish and Baldwin (2003) reported that the average effect size for marriage therapy was $d = .84$.

Based on their meta-analysis of meta-analyses, Snyder et al., (2006) concluded that couple therapy “demonstrates effectiveness in treating generalized relationship distress as well as comorbid relationship problems and individual emotional and behavioral difficulties” (p. 339). Although couple therapy is effective in improving relationship health, it also takes time. In a survey of 850 cases from various mental
health providers, the average number of sessions for couple therapy was 11.5 (Doherty & Simmons, 1996).

**Brief Therapy**

Some researchers argue that the typical 10-20 hours of therapy might be too brief for some couples to address their issues that have been drawn out over long periods of time (Gurman & Fraenkel, 2002). Other clinicians have created interventions that have become very brief. Some of these models rely on solutions, rather than focusing on specific problems. One such approach is solution-focused brief therapy. Several key assumptions of the approach is that change is constant and that individuals have their own strengths and resources to find solutions to their problems (De Jong & Berg, 2007; Thomas & Nelson, 2007).

The pressures placed on therapists to adhere to time-limited, cost-efficient models have contributed to the increased use of brief therapies (Jordan, 2001; Sharp, 1994; Vann, 1995). Although there has been controversy at what constitutes “brief therapy,” it has been argued that one to 20 sessions with an average of six sessions (Bloom, 1992) constitutes brief therapy, while others have argued, “what constitutes brief therapy . . . is not the setting of a time limit, but the establishment of a clear focus for the treatment” (Gurman, 1981, p. 420). Regardless of the disparity in definitions, brief therapy normally is much shorter when compared with “traditional” therapies that take at least six months (Sharp, 1994) and sometimes two to three years to complete (Gurman, 2001). Due to the push for time-limited, cost-efficient models, Jordan (2001) concluded that “the days of prolonged psychotherapy are long gone” (p. 67).
Single session psychotherapy has become somewhat more widespread in the last two decades. For example, the single session therapy (SST; Talmon, 1990) approach has become widespread enough that it has been applied to walk-ins (Cameron, 2007), children and adolescents (Perkins, 2006), clients that self-harm (Lamprécht et al., 2007), and families (Curtis, Whittaker, Stevens, & Lennon, 2002).

**Brief Couple Interventions**

As in brief individual therapy, couple therapy is gradually becoming briefer. For example, Davidson and Horvath (1997) tested whether a three-session therapeutic model could assist couples in conflict resolution and enhancing marital adjustment. Couples reported decreased levels of conflict and enhanced marital adjustment six weeks after treatment. Using the Reliability Change Index (RCI; Christensen & Mendoza, 1986) as a benchmark, the authors reported that 39% of the couples improved after three sessions.

Other researchers have developed very brief interventions for couples. For example, Halford, Moore, Wilson, Farrugia, and Dyer (2004) created the Couple CARE program which allows couples to choose goals that they believe would help them to relate better. Couple CARE outlines six, two-hour units including self-change, communication, intimacy and caring, managing differences, sexuality, and adapting to change. The couples watch video recordings of couples modeling appropriate behavior for each unit and create goals based upon what they experience through the recordings. Educators follow up on goals with the couples over the phone each week for six weeks. Couple CARE reported that couples had increased satisfaction after the program, yet the program did not decrease negative communication between partners.
Another example is the Marriage Check-up (MC; Cordova et al. 2001), a combination of marital education and marital therapy (Erwin, 2008). This intervention uses Motivational Interviewing which includes informing each couple about relationship deterioration and allowing the couple to decide when and how they want to improve. The Marriage Check-up is targeted to at-risk couples. The outcome data suggested that the intervention attracted couples that might not have sought therapy or marriage education. Cordova and his colleagues concluded that couples in the at-risk stage are an underserved population that does not normally seek couple therapy or enrichment programs and that “reaching out to at-risk couples should be a higher priority within the couple treatment community” (p. 324). There is a need for couple interventions that can help more couples improve their relationships.

Cordova and colleagues reported that couples improved their marital satisfaction significantly from pretreatment to posttreatment and maintained their satisfaction at a one month follow up. In the same study, Cordova et al. (2001) also emphasized the need for programs that can attract more couples in the general population who are beginning to experience distress, but who might not yet seek a ‘full’ intervention. Taken together, this research suggests that couple therapy that is briefer than the traditional couple therapy is gaining popularity and, in some cases, is effective in increasing marital satisfaction. A key purpose of Cordova and colleagues’ MC intervention was to attract couples that might not normally seek help in other avenues. This was also a goal of the current intervention. Basic differences between the Marriage Check-up and the current intervention include the theoretical approach (motivational interviewing versus solution
focused brief therapy), and the use of separate interviews for partners. Solution-focused therapy assumes that the client is the expert and has strengths and resources (Thomas & Nelson, 2007). In this intervention the consultants were collaborative in creating goals with the couples and assumed the couples could co-create solutions.

**Solution-Focused Brief Therapy (SFBT)**

An increasingly prominent approach of brief therapy is solution-focused brief therapy (SFBT), which was developed by de Shazer and Berg and colleagues (De Jong & Berg, 2007; de Shazer, 1982, 1985, 1988, 1991; Thomas & Nelson, 2007). SFBT is a brief approach to therapy because the therapist focuses on the client’s strengths and solutions, rather than seeking to explore the source of the problem. It assumes no underlying problems or symptoms require examining. The SFB therapist assumes that change is constant and clients have their own resources to overcome difficulties (Thomas & Nelson, 2007). Therefore, the therapist collaborates and tailors the therapy to the individual clients in the room. The word “brief” in SFBT means that therapy should have as few sessions as possible; not one more than is necessary (de Shazer as cited in Dolan, 1991). As a result, SFBT typically lasts six sessions or fewer (Gingerich & Eisengart, 2000). In other words, SFBT is brief, tailored to the individual, client driven, and strengths-based, thereby addressing many of the challenges of preventative marital education presented by Olson et al. (2009).

In some cases, the solution-focused therapist will use only one or two sessions (Gingerich & Eisengart, 2000; Rothwell, 2005). For example, in a study that compared cognitive behavioral therapy (CBT) with SFBT in treating adults with various presenting
issues, the average number of sessions for the SFBT approach was two sessions with many clients using just one session, whereas CBT averaged five sessions (Rothwell, 2005). Furthermore, solution-focused brief therapy has shown to help clients improve in a variety of different problems including parenting skills, depression, and recidivism rates in the prisons (Gingerich & Eisengart, 2000; Lee, 1997). Furthermore, in a meta-analysis of 22 studies, solution-focused brief therapy produced small, but positive trends on outcome measures (Kim, 2008).

SFBT has been applied to couples therapy in general (Chromy, 2007; Hoyt & Berg, 1998). Furthermore, solution-focused brief therapy has been used with a wide array of presenting problems for couples including weight loss (Dolan, 1997), partners coming out as homosexual (Treyger, Ehlers, Zajicek, & Trepper, 2008), premarital couples (Murray & Murray, 2004), male cross-dressers (Dzelme & Jones, 2001), and sexual dysfunctions (Ford, 2006; Trepper, Treyger, Yalowitz, & Ford, 2010). Solution-focused therapy has been shown to be effective with couples in group therapy (Zimmerman, Prest, & Wetzel, 1997). SFBT in another study of couple group therapy helped seven individuals out of five couples to improve their relationship satisfaction based on visual inspection (Nelson & Kelley, 2001). There is only one quantitative study that shows the effectiveness of using SFBT with couples, therefore, more quantitative research needs to be done to establish the effectiveness of SFBT with couples, particularly with very brief interventions involving less than six sessions. Furthermore, due to the lack of quantitative data from solution-focused brief couple therapy, more empirical evidence might help establish the effectiveness of SFBT especially working
with couples by themselves, and not in group settings. The current couple intervention was based on principles of SFBT; more details will be given later. Evaluation of the current intervention was focused on individual and relationship functioning. Attention is now given to these variables.

**Relationship Knowledge**

Relationship knowledge in this study is defined as an awareness, understanding, and knowledge of how to interact with one’s partner. Relationship awareness (i.e., thinking about and talking about the relationship), has been shown to predict relationship satisfaction (Acitelli, 1992). One study found that wives’ understanding of their husbands predicted wives’ relationship well-being (Acitelli, Douvan, & Veroff, 1993). Relational knowledge has been shown to affect the manner in which a couple might interpret events in their relationship (Planalp, 1987). Specific knowledge of how to communicate and how to listen to one’s partner has been essential in many models of therapy (Fowers, 2001), and in various education programs (Butler & Wampler, 1999; Halford, Markman, Kline, & Stanley, 2003). Furthermore, Gottman’s method of couple therapy, which is based on knowledge and an understanding of how to resolve conflicts, build friendship, and deepen love in relationships, has been shown to decrease relationship distress (Gottman, 1999).

**Communication Skills**

Couple communication has been a common focus for researchers and interventionists due to the linkages between communication and relationship satisfaction.
One of the main reasons couples seek therapy is to resolve problematic communication (Doss, Simpson, & Christensen, 2004), and therapy has been shown to help improve communication between partners. For example, in a study with 134 couples, Doss et al. (2004) showed that over an average of 22.9 sessions, couple communication patterns improved which resulted in a significant increase in marital satisfaction for both the husband and wife.

Communication skills have also played a major part in psychoeducation and enrichment programs. Most psychoeducation and enrichment programs emphasize communication skills (Halford et al., 2003; Lebow, 2006) reasoning that effective communication predicts marital satisfaction (Karney & Bradbury, 1995; Markman & Hahlweg, 1993). In a meta-analysis of 117 independent studies, researchers conclude that psychoeducation programs effect couples’ communication significantly ranging from .36 to .54 for experimental studies (Hawkins et al., 2008). Although communication was not a central component to the present intervention, communication was measured to examine any potential impact from the intervention.

**Individual Functioning**

Marital satisfaction has long been linked to personal well-being. For example, Proulx and colleagues (2007) in a meta-analysis of 66 cross-sectional studies and 27 longitudinal studies reported that higher levels of marital satisfaction are associated with higher levels of individual well-being. In addition, higher marital distress has been linked with lower individual functioning. For example, Whisman (2007) reported that marital distress was linked with individuals experiencing higher levels of anxiety and
increased mood and substance disorders. Marital dissatisfaction has also been shown to be associated with higher levels of depression over time (Beach, Katz, Kim, & Brody, 2003). Specific treatments have been developed as couple interventions to help one partner cope with numerous difficulties including obsessive compulsive disorder, agoraphobia, depression, sexual dysfunction, alcohol abuse, and schizophrenia (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Due to the correlation between marital satisfaction and individual well-being, individual well-being was measured in the present research to examine any potential impact from the intervention.

### Readiness for Change

Some researchers are beginning to examine clients’ readiness to change as a factor in treatment (Bradford, in press; Prochaska & Norcross, 2001). Readiness to change has been defined as affect and cognition that lead to change (Bradford, in press), and change through attempted behaviors (Carey, Purnine, Maisto, & Carey, 1999). In their Transtheoretical Model of Change (TTM), Prochaska and Norcross (2001) stated that change is a “process that unfolds over time and involves progression through a series of six stages: precontemplation, contemplation, preparation, action, maintenance, and termination” (Prochaska & Norcross, 2001, p. 443). Although this model has been traditionally applied to individuals, the current study applied the model to couples. The benefit of discerning readiness to change in couple therapy is that if therapists can identify which stage of change clients are experiencing, they might be able to tailor-treat the clients more effectively. For example, Prochaska and Norcross (2001) demonstrated that treatment that took the stages of change from the Transtheoretical Model of Change
(TTM) into account was more effective than treatment that did not use the stages of change for treatment.

Although several developments have occurred in the field of couple therapy, relatively little attention has been given to the client’s readiness to change (Bradford, in press). The models employed by therapists assume that clients are in the action stage; that is, the clients are modifying their behavior, environment, and experiences to address their problems (Prochaska & Norcross, 2001). The developers of the TTM argued that assuming all couples are in the action stage is not accurate nor beneficial to all clients (Prochaska & Norcross, 2001). Furthermore, the use of the transtheoretical model in couple therapy might not only help improve therapy outcomes, but it might offer insight to researchers of a contributor to the outcomes in therapy. For example, an individual that starts in the action stage might show more change in an intervention than an individual that starts in the precontemplation stage. It may also be that an intervention might facilitate movement from one stage to the next.

Summary

Many different interventions have been used to help couples improve their relationship including couple therapy, brief couple therapy, and education programs. Although there are many different interventions, interventions for couples that are very brief and client-centered, where the client determines fully the direction of the goals, still need to be explored in an effort to provide accessible services to larger numbers of couples who are beginning to experience distress. In addition, solution-focused brief therapy needs more research to establish its effectiveness for couples in interventions.
Research Questions

1. Does a brief two-session intervention using concepts from SFBT significantly improve (a) relationship quality, (b) relationship knowledge, (c) communication skills, and (d) individual well-being?

2. Does a brief intervention of two sessions help couples move from one stage of change to the next in the transtheoretical model?
CHAPTER III

METHODS

This section describes the research design, participants, procedures, and measures. In this pilot study, sessions were called ‘consultations’ and those facilitating the sessions were referred to as consultants. These terms were used rather than ‘sessions’ and ‘therapists’ to reduce potential stigma to those who might be apprehensive about relationship therapy.

Design

The research design for the current study was a pilot study. A pilot study is defined as “trying variables out on a handful of subjects before actually starting the experiment” (Leary, 2007, p. 194). A pilot study was used because there is not a lot of research on a two-session treatment for couples, especially using concepts from solution-focused brief therapy. The study used a repeated measures design. One of the advantages of the repeated measures design is that it requires relatively fewer participants in answering the research question (Leary, 2007). Having a repeated measures design allowed the current study to utilize the limited number of couples that volunteered for the intervention.

Participants

Participants consisted of 30 couples \( n = 60 \) recruited through advertisements placed in the university newspaper, the distribution of flyers, radio announcements, and posted on the internet. Each couple received $20 as compensation for participation.
Each participant signed an informed consent for research form before the initial session. The study was approved by the Utah State University Institutional Review Board (see Appendix A).

The male participants’ mean age was 30.63 and the females mean age was 28.10 (see Table 1). Of the males ($n = 30$) 73.3% self reported that they were married, 6.7% reported that they were living together, and 20% reported that they were dating/engaged. Of the males, 86.7% reported that they were never divorced, 6.7% reported being divorced once, and 6.7% reported being divorced twice. Of the males, 100% reported being Caucasian. Of the females, 96.7% reported that they were Caucasian. Of the females, 70% reported being married, 6.7% reported their status as living together, and 23.3 reported their status as dating/engaged. Of the females, 86.7% reported being never divorced, 10% reported being divorced once, and 3.3% reported being divorced twice. For the males the median household income was $25,000, while for the females it was $20,000.

**Procedures**

Based upon the suggestions of several scholars, manualized treatment was used (Davidson & Horvath, 1997; Pinsof, Wynne, & Hambright 1996). The Revitalize Manual (Bradford, 2010; see Appendix C) used five stages of solution-focused therapy to outline a two-session therapeutic approach based on solution-focused brief therapy (SFBT). The manual was developed with the client in mind. In other words, the consultants were instructed to do what the client needed using concepts from SFBT. The
consultants were trained on the five stages of solution-focused therapy including: (a) co-constructing a problem and goal, (b) identifying and amplifying exceptions (e.g., times when things have been better), (c) assigning tasks, (d) evaluating the effectiveness of the task, and (e) re-evaluating the goals (de Castro & Guterman, 2008). In addition, the consultants were trained to use other SFBT techniques such as focusing on solutions, using scaling questions, using the ‘miracle question,’ complimenting couples, and encouraging couples to do more of what works.

Couples called the Family Life Center at Utah State University (n = 26) or the Family Institute of Northern Utah (n = 4) to set up appointments to participate in the Revitalize treatment. Couples filled out a pre-assessment survey via the internet before the first meeting with the consultant; hard copies were offered to those without internet access. The consultants were six therapists (three males and three females) that were second year Master’s degree students studying Marriage and Family therapy, a licensed MFT, or an intern social worker. In Table 2, the experience, number of couples seen, and preferred model was included to offer more information on the consultants themselves.

### Table 1

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<th>Variables</th>
<th>Males</th>
<th>Females</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>30.63</td>
<td>11.70</td>
<td>28.10</td>
<td>11.36</td>
</tr>
<tr>
<td>Years living together</td>
<td>5.09</td>
<td>9.00</td>
<td>5.17</td>
<td>8.97</td>
</tr>
</tbody>
</table>
### Table 2

*Characteristics of the Consultants*

<table>
<thead>
<tr>
<th>Consultant</th>
<th>Experience</th>
<th>Number of couples seen</th>
<th>Preferred model of therapy</th>
<th>Difference in marital quality index pre-to post-</th>
<th>Difference in communication skills pre-to post-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant one</td>
<td>2nd year MFT graduate student</td>
<td>11</td>
<td>EFT</td>
<td>1.63</td>
<td>-0.27</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.27</td>
<td>1.54</td>
</tr>
<tr>
<td>Consultant two</td>
<td>2nd year MFT graduate student</td>
<td>7</td>
<td>SFBT</td>
<td>2.00</td>
<td>1.43</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.57</td>
<td>0.57</td>
</tr>
<tr>
<td>Consultant three</td>
<td>2nd year MFT graduate student</td>
<td>5</td>
<td>Rogerian, EFT, SFBT</td>
<td>-0.60</td>
<td>0.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-2.6</td>
<td>-3.40</td>
</tr>
<tr>
<td>Consultant four</td>
<td>2nd year MFT graduate student</td>
<td>3</td>
<td>ACT</td>
<td>-1.66</td>
<td>3.66</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.66</td>
<td>2.33</td>
</tr>
<tr>
<td>Consultant five and six(^a)</td>
<td>Licensed MFT/Intern social worker</td>
<td>4</td>
<td>Eclectic</td>
<td>-1.75</td>
<td>-2.25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.25</td>
<td>1.00</td>
</tr>
</tbody>
</table>

*Note.* EFT represents emotionally focused therapy, SFBT represents solution-focused brief therapy, ACT represents acceptance and commitment therapy, and Eclectic represents a combination of different models. Scores for female clients are in *italics.*

\(^a\) The data from couples seen at Family Institute of Northern Utah (FINU) were combined.
To exempt couples with violence present in the relationship, couples with at least one partner whose scores on the Intimate Justice Scale (IJS; Jory, 2004) indicated substantial risk were excluded. Couples with one partner who scored 15 or higher on the Outcome Questionnaire 10 were also excluded based upon the assumption that the treatment was insufficient to address such levels of individual distress in two sessions. Despite these criteria, no couples in this sample were excluded from the intervention.

During the first session, the consultant reviewed the assessment results including items from the Outcome Questionnaire 10, the Kansas Marital Satisfaction Scale, Intimate Justice Scale, the Gottman 17 Areas Scale, and the Readiness to Change Scale (see Appendix B) with the couple, highlighting the couple’s strengths and abilities to find solutions. During this first session, couples and consultants co-constructed goals, discovered and amplified positive exceptions, and then co-constructed tasks that couples were asked to work on over the next few weeks. This first session meeting usually lasted two hours, but in some cases (very roughly 25%) the initial session was shortened slightly based upon the needs of the couple. At the end of the consultation, consultants scheduled appointments for three or four weeks in the future.

Couples returned for the second session which began by the couple taking a brief assessment. During the second session, couples and consultant evaluated the effectiveness of the tasks they performed subsequent to the first session and re-evaluated their goals, setting new goals or modifying existing goals. At the end of session two, couples completed the post-session survey.
Measures

Marital Quality

The Quality Marriage Index (QMI; Norton, 1983) was used to measure the couples’ overall relational quality. The QMI is a six-item questionnaire which includes five items such as “we have a good marriage” and “my relationship with my partner makes me happy.” The items are scored on a 7-point Likert scale from strongly disagree to strongly agree. The sixth item asks the couple to rate their relationship on a 10-point scale ranging from very unhappy to perfectly happy. Analyses of the current data indicated that the measure was reliable with alpha levels ranging between .91 and .95. The Kansas Marital Satisfaction Scale correlated significantly with the QMI (Schumm et. al., 1986) which helped establish the validity of the QMI.

The QMI had scores ranging from 2 to 45 with the greater the score meaning, the more marital satisfaction. Heyman, Sayers, and Bellack (1994) determined the cutoff score for the QMI to be 29.26 for males and 29.23 for females. In the current data, only 20% of males were below the cutoff of 29.26 and 23.3% of females were below the cutoff of 29.23; thus, only 20-25% of the participants were relationally distressed.

Relationship Knowledge

The Relationship Knowledge Questionnaire (see Higginbotham, Bradford, Mock, & Skogrand, 2011) was used to measure participants’ levels of knowledge regarding relationships. This six-item instrument included statements such as “my knowledge of how to listen effectively to a spouse/partner.” The individual rates on a 4-point scale with responses being “was/is poor, was/is fair, was/is good, was/is excellent.” This measure
was taken prior to the first session. A posttest-then-retrospective-pretest evaluation (Marshall, Higginbotham, Harris, & Lee, 2007) was used at the second session, in which participants rated their knowledge of relationship skills on “what you knew BEFORE and now AFTER the program.” This was done to measure potential differences between true pretest means and retrospective pretest means. Higginbotham et al. (2011) reported that the Cronbach’s alpha for the instrument ranged from .60 to .87. In the current data, the alpha levels ranged from .79 to .87. Because this was a new measure, its validity has not yet been established. However, in these data, men’s and women’s scores correlated with marital satisfaction at .41 (p = .018) for pretest and .57(p = .001 at posttest for men and .30 (p = .019) for pretest and .52 (p = .003) at posttest for women. These preliminary data establish a degree of construct validity.

**Couple Communication**

The Pre-counseling Inventory (Stuart & Jacobson, 1987) was used to measure the quality of communication between the couple. The inventory included eight items such as “my partner/spouse listens attentively when I speak” and “my partner communicates affection by words as well as touch.” Items are scored on a five-point Likert scale ranging from (1) Never to (5) always. In the current data, alpha levels ranged from .84 to .94.

**Individual Functioning**

The Outcome Questionnaire 10 (OQ-10; Lambert et al., 1997) had 10 items, and was used to measure individual distress levels. Individuals rated well-being and distress on items such as “I am a happy person” and “I feel lonely” along a Likert scale from 0,
Never, to 4, Almost Always. The instrument was developed as a shorter version of the original Outcome Questionnaire 45-2. Seelert, Hill, Rigdon, and Schwenzefer (1999) reported that the OQ-10 had a Cronbach’s alpha coefficient of .88, demonstrating the internal consistency of the measure. The OQ-10 significantly correlated with the DUKE assessment measure (Seelert et al., 1999), thereby helping to establish construct validity for the OQ-10.

Readiness For Change

The Stages of Relationship Change Questionnaire (SRCQ; Bradford, in press) was used to measure couples’ stages of change. This instrument measured the respondent’s interest in making change in nine specific categories including leisure time, communication, finances, sex, roles and expectations, anger management, parenting, and overall satisfaction. Participants individually rated themselves on each of the nine categories by using one of five possible stages of change for each item. For example, participants chose 1 for the phrase “I don’t plan to make any changes,” 3 for “I am getting ready to make some specific changes,” and 5 for “I have recently made changes.” Bradford (in press) reported that the Stages of Relationship Change Questionnaire had a Cronbach’s alpha of .79 for males and .86 for females. Bradford (in press) also reported that as one might predict, the SRCQ significantly and negatively correlated with relationship adjustment as measured in the Revised Dyadic Adjustment Scale (RDAS; Busby, Crane, Larson, & Christensen, 1995; Crane, Middleton, & Bean, 2000) which helped to establish the validity of the SRCQ. Mean level of readiness for change will be reported to help describe the participants’ readiness for this intervention. It was
hypothesized that couples in lower stages of change would be relatively less likely to change.
CHAPTER IV
RESULTS

In this chapter, I address the research questions proposed at the end of Chapter II. The chapter describes the data analyses used for each of the research questions.

Research Question One

*Does a brief two session intervention using SFBT significantly increase the scores on various measures including (a) relationship quality, (b) relationship knowledge (c) communication skills, and (d) individual well-being?* This question was answered by comparing the scores on marital quality, relationship knowledge, communication skills, and individual well-being using a paired *t*-test analysis. Each measure was administered over the internet before the first session and each individual filled out a packet of the self-report measures before the second session except the relationship knowledge which was administered after the second session. In order to provide clarity, the measure taken over the internet was labeled as pretreatment and the measure taken before session two was labeled posttreatment.

Marital Quality

Scores on the QMI were calculated by adding the scores on all six questions, thereby giving an overall score on the measure. As shown in Table 3, the average score on the QMI for the males (*n* = 30) pretreatment was 35.66 and posttreatment was 36.02. The average score for the females (*n* = 30) at pretreatment 34.09 and 36.02 at posttreatment. Based on the *t* test analysis, the results were not statistically significant.
Table 3

*Marital Quality Pretreatment Versus Posttreatment*

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Sig. (p)</th>
<th></th>
<th>M</th>
<th>SD</th>
<th>Sig. (p)</th>
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</thead>
<tbody>
<tr>
<td>Pretreatment</td>
<td>35.66</td>
<td>8.49</td>
<td>.716</td>
<td>Females</td>
<td>34.09</td>
<td>9.46</td>
<td>.28</td>
</tr>
<tr>
<td>Posttreatment</td>
<td>36.02</td>
<td>7.68</td>
<td></td>
<td></td>
<td>36.02</td>
<td>8.30</td>
<td></td>
</tr>
</tbody>
</table>

**Relationship Knowledge**

Relationship knowledge scores were calculated by summing the scores on each item. The after second session Relationship Knowledge Questionnaire featured two columns where the couples rated their knowledge before the intervention and their current relationship knowledge. Therefore, the couple had to retrospectively look back and rate their relationship knowledge before the first session.

As shown in Table 4, the “true pre-score” for males was $M = 18.39$, the retrospective pre-score was $M = 16.77$, and the post-score was $M = 20.66$. For the females, “true pre-score” was $M = 18.82$, the retrospective pre-score was $M = 16.80$, and the post-score was $M = 20.43$. In Table 4, the questionnaire scores are compared using a $t$ test analysis. In all comparisons, the scores were statistically significantly different.

Note in Table 4 that the retrospective scores are lower than the “true pre-scores”. Possible reasons for the differences will be addressed in Chapter V.
Table 4

*Relationship Knowledge Pretreatment Versus Posttreatment*

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th></th>
<th></th>
<th>Females</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SD</td>
<td>t</td>
<td>p</td>
<td></td>
<td>SD</td>
<td>t</td>
<td>p</td>
</tr>
<tr>
<td>True pre</td>
<td>18.39</td>
<td>2.92</td>
<td>-3.63</td>
<td>.001</td>
<td>18.82</td>
<td>2.76</td>
<td>-3.45</td>
<td>.002</td>
</tr>
<tr>
<td>Post</td>
<td>20.66</td>
<td>2.26</td>
<td></td>
<td></td>
<td>20.43</td>
<td>3.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retrospective pre</td>
<td>16.77</td>
<td>3.30</td>
<td>-7.85</td>
<td>.000</td>
<td>16.80</td>
<td>4.25</td>
<td>-6.90</td>
<td>.000</td>
</tr>
<tr>
<td>Post</td>
<td>20.66</td>
<td>2.26</td>
<td></td>
<td></td>
<td>20.43</td>
<td>3.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>True pre</td>
<td>18.39</td>
<td>2.92</td>
<td>2.59</td>
<td>.016</td>
<td>18.82</td>
<td>2.76</td>
<td>2.99</td>
<td>.006</td>
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<tr>
<td>Retrospective pre</td>
<td>16.77</td>
<td>3.30</td>
<td></td>
<td></td>
<td>16.80</td>
<td>4.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Communication Skills**

Communication scores were calculated by summing eight items from the Pre-Counseling Inventory. The scores in Table 5 represent pretreatment versus posttreatment. For the males, the mean on the initial inventory was 31.33, and 31.73 on the posttreatment inventory. For the females, the mean on the initial inventory was 30.60 and the mean on the posttreatment inventory was 31.10. Although the scores increased for both males and females from time one to time two, the increase was not statistically significant as shown in Table 5.

**Individual Functioning**

Individual functioning scores were calculated by summing the 10 items from the Outcome Questionnaire 10. The scores in Table 6 represent the scores from pretreatment versus pre-session two.
Table 5

*Communication Skills Pretreatment Versus Posttreatment (n = 30)*

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Sig. (p)</th>
<th></th>
<th>M</th>
<th>SD</th>
<th>Sig. (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre treatment</td>
<td>31.33</td>
<td>6.14</td>
<td>.53</td>
<td>Females</td>
<td>30.60</td>
<td>6.71</td>
<td>.48</td>
</tr>
<tr>
<td>Post treatment</td>
<td>31.73</td>
<td>5.00</td>
<td></td>
<td></td>
<td>31.10</td>
<td>6.04</td>
<td></td>
</tr>
</tbody>
</table>

For the males the initial mean was 12.47 and the posttreatment mean was 10.67.

For the females, the mean was 13.43 pretreatment and 11.23 at posttreatment. Seelert et al. (1999) reported that the clinical cutoff for the Outcome Questionnaire 10 ranged from 12 (conservative) to 17 (liberal). The cutoff for this study was thus set at 14.5. Of the males, 33% were above the clinical cutoff at pretreatment and 30% were above at posttreatment. Of the females, 47% were above the clinical cutoff at pretreatment and 27% were above at posttreatment. The decrease in scores from pretreatment to posttreatment were statistically significant for both males and females, suggesting that both men and women improved in their levels of individual well-being.

**Research Question Two**

*Does a brief intervention of two sessions help couples move from one stage to the next in the Transtheoretical Model?* A t-test analysis was used to answer this research question.

Table 6

*Individual Functioning Pretreatment Versus Posttreatment (n = 60)*

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Sig. (p)</th>
<th></th>
<th>M</th>
<th>SD</th>
<th>Sig. (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretreatment</td>
<td>12.47</td>
<td>6.74</td>
<td>.037</td>
<td>Females</td>
<td>13.43</td>
<td>6.07</td>
<td>.045</td>
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<tr>
<td>Posttreatment</td>
<td>10.67</td>
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<td></td>
<td></td>
<td>11.23</td>
<td>4.93</td>
<td></td>
</tr>
</tbody>
</table>
question. The stages of relationship change questionnaire (SRCQ) was administered over the internet before the intervention and given to the couple in pencil/paper form immediately after the intervention was completed. The transtheoretical model is made up of six stages that include precontemplation, contemplation, preparation, action, maintenance, and termination. The SRCQ was designed to measure change in various areas of the relationship. Each individual was to rate each area as “I don’t plan to make any changes,” “I’m thinking about making changes,” “I am getting ready to make some specific changes,” “I am actively making specific changes,” and “I have recently made changes and I am working to prevent problems from returning.”

The scores on the SRCQ were calculated by summing the scores on each of the nine items. In Table 7 the summed means for the nine items are provided; males scored 16.93 at pretreatment and 17.80 at posttreatment. For the females the summed means were 17.37 at pretreatment versus 19.27 at posttreatment. Although both means showed movement in a positive direction, the differences between the means were not statistically significant as shown in Table 7. Stage of change was calculated for males and females by dividing the overall scores on the SRCQ by 9 (the number of items on the SRCQ). In other words, the mean for the males was 1.88 at pretreatment and 1.98 at posttreatment. The mean for the females was 1.93 at pretreatment and 2.14 at posttreatment. Based upon cutoff scores from Bradford (in press), men started in the contemplation stage (1.88) and remained in the contemplation stage (1.98). The women started in the contemplation stage (1.93) and remained in the contemplation stage (2.14) at posttreatment. These results suggest that this sample was contemplating change, but
neither men nor women were ready for behavioral change; nor did the intervention move participants along in terms of stage of change.

**Differences in Treatment**

In order to describe potential differences between consultants and fidelity to the treatment manual, an ANOVA was used to compare all six consultants. The differences from the Quality Marriage Index and the Pre-counseling Inventory are shown in Table 2 along with the experience of each consultant, and the number of couples that each consultant treated. The ANOVA, which took into consideration the scores from the quality marital index, the pre-counseling inventory, the relationship knowledge questionnaire, and the stages of relationship change questionnaire, showed no statistically significant difference between the six consultants and no statistically significant differences between consultants at FINU and consultants at the Family Life Center.
CHAPTER V
DISCUSSION

The purpose of this study was to test the feasibility and effectiveness of a two-session, client-centered, solution-focused intervention for couples. More specifically, the study examined if a two-session solution-focused intervention could help couples significantly improve their relationship quality and relationship knowledge; it also explored the potential impact on communication skills and individual well-being. Furthermore, the intervention was tested to observe any impact on stage of relationship change. In this chapter implications, limitations, and future research will be discussed.

Research Question One: Impact of the Intervention

The first research question tested the impact of this two-session couple intervention. In this sample of 30 couples, no statistically significant changes occurred in the areas of relationship satisfaction and communication skills. These results are not entirely consistent with the other research which reported statistically significant change in marital satisfaction using brief couple interventions (Cordova et al., 2001; Davidson & Horvath, 1997). Although not statistically significant, the results of this pilot test showed positive movement on all scores from lower scores at pretreatment and higher scores at posttreatment which supports the evidence presented in the meta-analysis of SFBT interventions that show positive trends (Kim, 2008). One possible explanation for the lack of change in relationship satisfaction and communication skills are the characteristics of the participants. The data show that the couples who were recruited for
this pilot study were overall very satisfied with their relationships. Eighty percent of males scored above the cutoff score and 76.6% of females scored above the cutoff score, suggesting that only between one-fifth to one-fourth of the participants were experiencing distress. Perhaps improvement on the measures was somewhat unlikely because the couples’ scores were too close to the ceiling at pretreatment, allowing relatively less room for improvement. Furthermore, the high relationship satisfaction of the participants might also have helped support one of the purposes of the intervention-attracting couples that might not seek conventional therapy. The couples in this study were not distressed in their relationships as couples that commonly seek therapy are (Lebow, 2006). In fact, the data suggested that these participants may even be less relationally distressed than other non-clinical samples. For example, one study of non-clinical couples reported that 33% of the sample was below the clinical cutoff for marital satisfaction (Bradford, in press).

Males in the study were in the pre-contemplation stage while the females were in the contemplation stage. In the current study, only 20% of males and 23.3% of females were below the cutoff, suggesting that the sample in the current study was relatively less distressed.

Although there are several explanations given to justify the lack of statistical significance in marital quality, couple communication, and readiness to change, another possible explanation is that two sessions do not provide couples with sufficient time to make changes. Perhaps having more than two sessions could help couples reach their relationship goals. Furthermore, due to the lack of evidence provided for the SFBT approach with couples (Nelson & Kelley, 2001; Zimmerman et al., 1997), perhaps the
approach is not effective in producing clinically significant results in areas of relationship quality and communication skills. Still, this model has been applied to couples with some success (e.g., Stith, Rosen, McCollum, & Thomsen, 2004).

Although the couples in the study were typically not distressed, the results indicated statistically significant improvements in relationship knowledge and individual well-being for both men and women. These results should be taken very tentatively because this study is a pilot test and lacks the sample size to make the findings generalizable. Yet for these participants, the intervention helped in some way to improve the relationship knowledge (awareness, understanding, and knowledge) between the couples. In addition, it may be that the intervention helped individuals realize that they have the strengths and resources (Thomas & Nelson, 2007) to help their relationship.

One possible explanation for the increase in individual functioning was that the clients were encouraged to set any goals that they wanted. Many clients set individual goals and relationship goals. It may be that the intervention helped some individuals focus on meaningful individual goals that contributed to their positive individual functioning.

These results represent a small contribution to the growing body of work using SFBT interventions with couples (Nelson & Kelley, 2001; Zimmerman et al., 1997). The positive trends in marital quality, communication skills, and readiness to change combined with the statistically significant results in relationship knowledge and individual functioning provide modest evidence that a solution-focused brief couple intervention helps to improve psychological well-being. This finding is potentially
important given the link between individual well-being and marital well-being (Proulx et al., 2007). The findings also suggest that even a brief intervention is supportive of relationship knowledge. Although more research needs to be done to support these initial findings, these results help support the notion that a very brief, solution-focused, client centered intervention may be beneficial for couples.

One might draw several conclusions from the statistically significant difference between the “the true pre-score” on relationship knowledge and retrospective pre-score. The “true pre-scores” measuring relationship knowledge (i.e., the scores reported after session one) were significantly higher both for males and females ($M = 18.39$ and $M = 18.82$, respectively) than the retrospective measure ($M = 16.77$ for males and $M = 16.80$ for females) which was taken posttreatment. In other words, after the intervention, couples reported retrospectively that they actually knew less than they had reported at the initial phases of the intervention. Perhaps couples did not know that they lacked knowledge until after the intervention was over. In other words, it is possible that the intervention helped them to realize that they did not know as much as they thought about their relationship or how to behave in their relationship. This finding has implications for all results in this study. Had other variables of interest been measured retrospectively as well, it is possible that participants may have rated themselves differently (possibly lower) on measures of satisfaction and communication. Regardless, the significant difference between the “true pre-score” and the retrospective pre-score suggests that the intervention had impact on participants’ knowledge.
Research Question Two: Stage of Change

The transtheoretical model was used in this study to describe individuals’ readiness for change and to see if the intervention had impact on stage of change. Given a strong enough impact, one might expect a brief intervention could help the participants move from a beginning stage to latter one over the course of the intervention. In this study, however, men and women both started and ended in the contemplation stage. The contemplation stage is characterized by knowing that a problem exists and thinking about changing, but not yet taking any behavioral action toward change (Prochaska & Norcross, 2001). In this stage, the individual considers changing problematic behavior in the next 6 months (Prochaska & Norcross, 2001).

The intervention did not facilitate significant change from one stage to another. A likely explanation for the lack of statistically significant change was, again, that the individuals in the study were largely satisfied with their current situation. For example, the contemplation stage does not involve any behavioral action and an individual might remain in the stage for long periods of time (Prochaska & Norcross, 2001), therefore, the intervention may not have produced the desired results in marital quality, communication skills, and readiness to change because the couples were content being in the contemplation stage and not ready to make changes. Because the intervention is designed for couples who are beginning to experience problems, screening couples to accept only at-risk couples that are not so satisfied with their current relationships would help better test the intervention on precisely the intended population.
Limitations

This study focused on describing an intervention’s pilot test of feasibility and effectiveness with thirty couples. There are several limitations to this pilot test. The number of participants was small. Because the study was a pilot test, the sample size did not offer as much statistical power as a larger sample size could have offered. In addition, the participants lacked diversity including ethnicity and race, due to the small sample size.

Another limitation to the current study is that fidelity was not closely tracked. Fidelity refers to delivering the intervention in a “comparable manner to all participants and is true to the theory and goals underlying the research” (Dumas, Lynch, Laughlin, Smith, & Prinz, 2001, p. 38). Although the treatment was manualized and consultants were trained and instructed to follow the solution-focused steps as outlined, consultants only received one session of training. Although the principal investigator did observe several sessions to check fidelity, there was no mechanism in place to regularly examine each consultant to ensure that the intervention was delivered in a comparable manner. Thus, there may be been variability in treatment delivery and the results might have been affected. Furthermore, the fact that each consultant did not prefer the approach of the current intervention (SFBT) might mean that the consultants did not remain true to the treatment manual. Although the results might have been affected and the consultants preferred different models, the results from the ANOVA comparing all consultants showed no statistically significant differences between the consultants. In other words, no one consultant was significantly different in results when compared with other
consultants. Another limitation of the current study is the lack of longitudinal follow-up data. Because of the nature of this pilot test, longitudinal data were not included. In future testing, longitudinal data might provide a more complete picture. For example, couples that attended the intervention might not have seen instantaneous results, but may have improved after the intervention was completed.

One other limitation was that the study did not determine how likely the couples would have been to seek couple therapy. This question was inadvertently left out of the battery of measures that were administered over the internet. By knowing the likelihood that the couple would seek couple therapy, I might better determine if this intervention targeted a different population than would normally seek therapy. Although the two-session model might be framed as an essential aspect of the study, it might also be a limitation of the study. Perhaps two, two-hour sessions of SFBT does not give enough time for at-risk couples to change their relationship quality and communication skills. Such a conclusion is supported by some of the research. For example, medium dosage marriage education programs (9-20 hours) had drastically larger effect sizes (many were statistically significant) than low dosage marriage education programs (1 to 8 hours) when examining areas of relationship quality and communication skills (Hawkins et al., 2008).

This pilot test was the first step in developing and testing the current intervention. In the future, the intervention will need a fidelity measure that helps to more closely ensure standardized treatment. In addition, future studies might benefit having more couples participate to gain a representative sample or perhaps screen for a sample that is
at-risk (Cordova et al., 2001). For example, Cordova and colleagues (2001) screened couples for the Martial Check-up to eliminate those that were so happy that the intervention might not apply. In addition, advertising to more of the community in future research might help reach more at-risk couples that could use the intervention. In the current study, the advertising attracted many couples from Utah State University who had been together for relatively brief periods of time and were largely happy with their relationships. Furthermore, collecting more longitudinal data could track on the longevity of effects. Currently, qualitative research is being done with the same couples who participated in the study to determine future improvements to the development of the intervention.

**Clinical Implications and Conclusion**

Although there are many couples who enter therapy “hovering on the tipping point of getting divorced” (Lebow, 2006, p. 175), the current data suggest that this intervention attracted couples who were largely satisfied with their relationships, rather than those beginning to experience relationship distress. If later versions and marketing strategies prove to attract more couples in distress, and versions of this intervention are found to be effective with target populations, the intervention might be used to support couples before they get to the point of divorce. In addition, presenting the intervention in a non-therapeutic manner (Cordova et al., 2001) might help attract couples who might be apprehensive about seeking couple therapy. Perhaps individuals that would not seek therapy might come to a non-threatenining intervention and continue with couple therapy. Six couples in the current study continued on with couple therapy. Perhaps these six
couples would not have sought couple therapy, yet were more comfortable with the idea of couple therapy after attending the intervention. The concept of appealing to couples before they experience significant distress might also apply to those that work in fields other than mental health (Erwin, 2008).

This pilot test is the first step in the development of a two-session couple intervention. Future steps include experimental designs that address target populations appropriately, tend more closely to fidelity, and test the research questions on a larger scale with more participants.
REFERENCES


Construct hierarchy and multidimensional scales. *Journal of Marital and Family Therapy*, 21, 289-308.


doi: 10.1111/1467-6427.00044
APPENDICES
Appendix A: Institutional Review Board Approval
Certificate of Exemption – Category #4

FROM: Richard D. Gordin, Acting IRB Chair
     True M. Fox, IRB Administrator

TO: Kay Bradford
    Jim Mock, Wade Stewart

DATE: 7/11/2011

RE: Protocol # 2983

TITLE: Recitalize - for Couples

The Institutional Review Board has determined that the above-referenced study is exempt from review under federal guidelines 45 CFR Part 46.101(b) Category #4: Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

This exemption is valid for three years from the date of this correspondence, after which the study will be closed. If the research will extend beyond three years, it is your responsibility as the Principal Investigator to notify the IRB before the study’s expiration date and submit a new application to continue the research. Research activities that continue beyond the expiration date without new certification of exempt status will be in violation of those federal guidelines which permit the exempt status.

As part of the IRB’s quality assurance procedures, this research may be randomly selected for continuing review during the three year period of exemption. If so, you will receive a request for completion of a Protocol Status Report during the month of the anniversary date of this certification. In all cases, it is your responsibility to notify the IRB prior to making any changes to the study by submitting an Amendment/Modification request. This will document whether or not the study still meets the requirements for exempt status under federal regulations.

Upon receipt of this memo, you may begin your research. If you have questions, please call the IRB office at (435) 797-1821 or email to irb@usu.edu.

The IRB wishes you success with your research.
Appendix B: Measures
### A. About How You’re Feeling

How have you been feeling over the last week? Mark the most accurate answer on each item.

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am a happy person.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. I am satisfied with my life.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. I am satisfied with my relationships with others.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. I feel loved and wanted.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. I feel my love relationships are full and complete.</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>6. I feel fearful.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I feel something is wrong with my mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I feel blue.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I feel lonely.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I feel stressed at work/school.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### B. About Your Communication

Check the box that best represents your answer.

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My partner/spouse listens attentively when I speak.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My partner understands what I communicate.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My partner is interested in learning about my ideas and feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My partner shares his/her ideas and feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. My partner compliments me for the positive things I do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. My partner communicates affection by words as well as touch.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. My partner is careful not to criticize too many of my ideas or feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
8. My partner enjoys just sitting and talking with me. | 1 | 2 | 3 | 4 | 5

C. About your relationship

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have a good marriage</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>My relationship with my partner is very stable.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Our marriage is strong.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>My relationship with my partner makes me happy.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I really feel like part of a team with my partner</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Circle the point that best describes the degree of happiness in your marriage.

<table>
<thead>
<tr>
<th>Happiness Level</th>
<th>Very Unhappy</th>
<th>Happy</th>
<th>Perfectly Happy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
D. About Change

The Stages of Relationship Change Questionnaire:

Considering your relationship, decide which of the following statements best completes the sentence on the right. Write “N/A” beside any of the numbered statements on the left that do not apply to your relationship.

(Note: You may use letters a - e more than once.)

Your response:

___ 1. …about how we spend our leisure time together.  ___ 6. …about our roles and the expectations we have for each other.

___ 2. …about how we communicate while solving problems.  ___ 7. …about managing my anger and avoiding physical aggression.

___ 3. …about how we communicate our affection.  ___ 8. …about how we raise our children.

___ 4. …about how we handle our finances.  ___ 9. …about my overall satisfaction with our relationship.

___ 5. …about sex with my partner.

a) I don’t plan to make any changes…

b) I’m thinking about making changes, but have not made any specific decisions yet…

c) I am getting ready to make some specific changes…

d) I am actively making specific changes…

e) I have recently made changes and I am working to prevent problems from returning…
E. About Your Experience

Please circle the answer that reflects your knowledge.

<table>
<thead>
<tr>
<th></th>
<th>Is Poor</th>
<th>Is Fair</th>
<th>Is Good</th>
<th>Is Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>My knowledge of how to listen effectively to a spouse/partner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My awareness of how to settle disagreements well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My understanding of how to solve problems and reach compromise.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My understanding of ways to deepen a loving relationship.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My knowledge of ways to have a strong friendship with a spouse/partner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My awareness of the importance of spending time together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

F. About Your Experience

Please circle the answer that reflects what you knew BEFORE and now AFTER the program.

<table>
<thead>
<tr>
<th>BEFORE the Program:</th>
<th>Is Poor</th>
<th>Is Fair</th>
<th>Is Good</th>
<th>Is Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Now, AFTER the Program:</th>
<th>Is Poor</th>
<th>Is Fair</th>
<th>Is Good</th>
<th>Is Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
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<td>4</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix C: Treatment Manual
Revitalize
Treatment Manual

What is it?

Revitalize is a 2-session protocol, ideally targeting ‘at risk’ couples who are beginning to have problems but who might not yet consider treatment. It aims to identify couple strengths and challenges, provide tools for self-help, and facilitate entry to treatment for those whose needs are more acute.

Protocol Overview

(a) Each partner completes a substantial assessment packet online prior to the first session.
(b) The couple then comes in a 2-hour session to get their results and discuss their strengths and challenges. The interventionist will already have the compiled results in hand when the couple arrives. Resources are given as appropriate.
(c) After 3-4 weeks, the couple again has another 2-hour session to evaluate their progress and direction. Again, resources and referrals are given as appropriate. The intervention may spur the couple to further treatment, or to continue work on their own.

The assessment, completed before each session, serves at least two purposes: first, it gives both the couple and the interventionist a rigorous analysis of the relationship, and second, the assessment itself helps couples begin to think about certain areas of their relationship and begin to make changes. Research suggests that such an evaluation may help facilitate positive change (Larson, Vatter, Galbraith, Holman, & Stahmann, 2007).

Theoretical Foundation

Revitalize is based on two theoretical foundations: (1) person-centered therapy generally, and (2) Solution-Focused Brief Therapy. The basic premise of both is that the client’s world is to be understood and valued, and that clients hold the keys to solutions. If a person can become aware of what is happening inside, and between her/him and others, s/he will know what is best.

Revitalize employs philosophy and techniques from Solution-Focused Brief Therapy, in that the focus is on positive outcomes, possible outcomes, partial successes, and client creativity. Be taught by the clients. An important stance is tentativeness: a stance of making room for clients to explore and expand possibilities, and ‘in-form you’ (Thomas & Nelson, 2007, p. 8). Tentative language such as ‘I wonder if...’; ‘This might be...’; ‘Is it possible that...’ (Thomas & Nelson, 2007, p. 8) can help spark and encourage new possibilities.
Active Ingredients in *Revitalize*


*Revitalize* takes seriously the idea that a great deal of ‘therapeutic change’ comes from ‘extratherapeutic change,’ meaning change outside of therapy. Your job is to help facilitate client change in session, but more importantly, outside of session. Handouts and resources will maximize their work.

Couples will identify strengths and challenges in their relationships.
You will help them to do this in the following ways:

1. Standardized assessments
2. Their written comments in the assessment packet (this will guide you toward their goals)
3. Comments in Sessions 1 and 2.

**During Session 1, collaboratively form 3 goals. These will be the core of treatment.**

- A client will say, or hint at, what s/he needs to deal with and will get as close as s/he can stand to, and then may back off. *If you actively listen, you will hear and will verbalize what they’re feeling.*
- Teaching the couple is helpful if the problem is a lack of information.
- Once you have created together 3 goals, (Session 1), you will use SBFT techniques to detail feelings, behaviors, and thoughts of what it will be like when they’re achieved.

2. The Client-Consultant (therapist) relationship.

The relationship between you and the couple is perhaps the most important part of the intervention. Lambert’s (1992) research suggests that the therapeutic relationship accounts for roughly 30% of the variance in client outcomes – and client variables account for 55%. Our techniques account for only 15%. There are three parts to your relationship that are most important (Rogers, 1957).

**Do all in your power to maintain these three conditions:**

- **Congruence.**
  - You are real and genuine in the relationship. You are truly yourself.
- **Unconditional Positive Regard.**
  - You feel warmly toward the clients – toward their problems as well as their potentials.
  - You *prize* them and feel care for them.
- **Empathic Understanding.**
  - You have *accurate* empathetic understanding of your clients.
  - The client’s world become clear to you – you can move about in it freely.
    - First, make empathic statements (minimize questions). Once you have actively listened, ask solution-focused questions.
You can voice meaning and emotion of which they are scarcely aware. Connect with both partners, particularly when one is more silent or withdrawn. Try to voice the experience of that person.

‘We need not always find exceptions or too quickly move away from...emotions. Feeling talk can sometimes be the best solution talk’ (Piercy, Lipchik, & Kiser, 2000, p. 26).

**Modes**

Know your two modes:

1. Facilitator/Therapist: Fostering self-actualization and relationship actualization through **active listening and responding**.

2. Consultation/Counseling: Offering direct information (e.g., education, coaching).

Use facilitator mode as often as you can. However, fit the mode and your style with the clients’ needs.

**Assessment**

Assessment is an on-going process. You will have the formal assessment results prior to meeting with the couple, but you will always be learning about the couple.

**Steps to Solution Focused Consultation**

There are typically 5 stages to solution-focused therapy (de Castro & Guterman, 2008):

<table>
<thead>
<tr>
<th>Step</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Co-construct a goal.</td>
<td>1</td>
</tr>
<tr>
<td>2. Discover and amplify exceptions.</td>
<td></td>
</tr>
<tr>
<td>3. Assign tasks.</td>
<td></td>
</tr>
<tr>
<td>4. Evaluate the effectiveness of tasks.</td>
<td>2</td>
</tr>
<tr>
<td>5. Re-evaluate the goals.</td>
<td></td>
</tr>
</tbody>
</table>

Generally, the first three stages will take place in the first session. The last two will take place in the second. But, you may include any element at any stage, depending on the clients’ needs.

**When is Revitalize Inappropriate or Insufficient?**

This program is briefer than most couple interventions, and certain couples may need to be referred to other forms of treatment.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Instrument</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Violence / Abuse</th>
<th>Intimate Justice Scale (IJS)</th>
<th>In general, follow up on items when score is above 30.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range: 15 – 75</td>
<td></td>
<td>• Conduct individual interviews if the IJS scores exceed 40, and/or if IJS items 14 &amp; 15 are 3+.</td>
</tr>
<tr>
<td>• 30-45: Moderate risk.</td>
<td></td>
<td>• Follow the Bradford (in press) protocol for IPV. [Journal of Family Psychotherapy].</td>
</tr>
<tr>
<td>• 45 or higher: High risk.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[251x636]talk’ (Piercy, Lipchik, & Kiser, 2000, p. 26).
### Insufficient:

| Personal Distress/Pathology | OQ 10 | Follow up on scores that are 15 or higher.  
|-----------------------------|-------|-----------------------------------------------------------------|
|                             | Range: 0 – 40 |   - Assess for (a) suicidal ideation, (b) substance abuse (see below), (c) harm to self and others.  
|                             | 15 or higher: At risk. |   - Where needed, give additional assessments (e.g., depression inventory, anxiety inventory) and ensure the client seeks further treatment as appropriate. |

### Appropriate:

| Substance abuse | Alcohol-focused couple therapy is the treatment of choice for couples where there is alcohol abuse (Gottman, 1999). Refer out as needed.  
|-----------------|-----------------------------------------------------------------|
|                 |   - Ask questions to understand how substance abuse issues may threaten partners’ safety and progress.  
|                 |   - In most cases, however, Revitalize is an acceptable treatment for individuals who use substances occasionally or even moderately. |

*As always, seek supervision as these and other issues arise.*

*Revitalize* is built upon the systems notion of circularity, and assumes that each couple has their own unique patterns. It is built largely on solution-focused ideology, which looks to promote more of what works, and focuses on exceptions – times when the problem wasn’t a problem. Conversely, the MRI model, which has a similar foundation, assumes that failed attempts to solve the presenting problem have become the problem. Your task will be to facilitate exceptions and encourage patterns that work for the couple.

Follow the maxim ‘If it ain’t broke, don’t fix it! Once you know what works, do more of it! If it doesn’t work, then don’t do it again – do something different’ (Berg & Miller, 1992, p. 17).

### Session 1

This Session Includes Steps 1-3:  
(1) Co-construct a goal, (2) Discover and amplify exceptions, (3) Assign tasks.  

*Take a short break about ½ hour before the session ends, as described.*
Couples will be receiving their assessment results from you for the first time during the first session. All assessment data will be important for you to review, but **section ‘H’ and ‘Ji’ are to be used actively.**

**Join**

Try to build rapport, make space for partners’ views and theories and establish a team (consultant-couple alliance) framework. Let the couple know you’ll take a break about ½ hour before the session ends. The following are good opening questions:

- How can I be helpful to you?
- What was it like taking the assessment?
- Have there been any small changes since taking the assessment?
- What needs to happen here so that when you leave you will think, ‘It was good that we went to see this consultant’? (What can we begin today?)
- What can I do that would help you two work better together at building on your strengths, or turning your relationship around?

**Review the Assessment Packet**

a. Give the couple their ‘results’ packet. Talk through the various components, but time will be short, so make it somewhat brief.

b. **Cut-off scores:** If the scores from the OQ (section A) or the IJS (section F) warrant it, say ‘I often speak individually to each person, and would like to do this now.’ If the OQ score is 15 or higher, assess for problems as indicated in this box:

| Section A (OQ 10) | •Assess (a) suicidal ideation, (b) substance abuse, (c) harm to self or others.  
|                   | •Give additional assessments (e.g., depression inventory, anxiety inventory) and ensure the client seeks further treatment as appropriate. |
| Section F (IJS)   | Conduct individual interviews and/or if IJS items 14 & 15 are 3+.  
|                   | •Follow the Bradford (in press) protocol for IPV. [Journal of Family Psychotherapy]. |

1. **Co-construct goals**

Using section ‘H’ and ‘Ji’ you can discuss couple strengths & challenges. Be sure to digest these data. Get more detail as needed.
Listen to the couple. What is important to each person? Understand each person’s world view, and co-construct with them an attainable goal. Using concepts presented in the assessment, look for the concerns that are most pressing to them.

a. **Use section ‘H’ to guide the interview.** Investigate the areas that were most important to the couple (each person has indicated three items that are most important). **These could be strengths they want to continue.** If they’d like to build on these strengths, ask solution-focused questions designed to take them to the next level. For challenges, ask the questions as below.

**Use the miracle question.**

‘Suppose that one night there is a miracle. While you slept, your relationship with each other suddenly became better – *fresher, closer to how you really feel about each other, or would like to feel about each other.*

If this happened, how would you know? What would be different?

What would you be...

- Feeling? *(affect)*
- Doing? *(behavior)*
- Thinking? *(cognition)*

**From general to specific.**

- How will the two of you know you have solved the problems that bring you here?
- How will things be different?
- What specifically will tell you that you have solved your problem or reached these goals?
- What will be the first signs (smallest steps) that will tell you that you two are moving in that direction? What else?

**Getting specific details – painting the picture.**

- What will tell you that you are on track? What else?
- What will that look like?
- What else will be different?
- When you are on track, what will you notice, what will be different to give you the confidence that you two will keep heading in that direction even after we stop meeting?

**2. For Each Goal: Discover and amplify exceptions**
Ask questions like:
‘When has there been a time you coped better with the problem?’
‘What were you doing when things were better?’
‘How did you make this happen? How did each of you do your own part?’
If they can’t find exceptions, ask about small differences. Then, ask about potential differences.
‘What is one small thing you will be doing when things are going smoother?’

**Use scaling questions.**

Use this tool to help the client identify useful differences and to help establish goals. The poles of a scale typically range from the “worst the problem has ever been” (zero to one) to the best things could possibly be” (ten). Ask the client what their current position is on this scale, and questions are used to help the client identify:

- Resources: “what’s stopping you from slipping one point lower down the scale?”
- Exceptions: “on a day when you are one point higher on the scale, what would tell you that it was a ‘one point higher’ day?”
- Describe a preferred future: “where on the scale would be good enough? What would a day at that point the scale look like?”

The following model may be used as a guideline to help you move from one level of change to the next:

```
START

Hopes
No

Exceptions: times when the problem is less acute or aspects of life not so bad
No

Coping strategies: perseverance, not giving up hope, etc.
No

History of past successes, achievements, etc.

Yes

Exploration of preferred future: e.g. miracle question

Yes

Times when a preferred future already happens (e.g. scales)

Yes

Next small step towards goal (e.g. scales again)

Compliments
```

**FINISH**
3. **Assign EXPERIMENTS (Tasks)**

Use the *Revitalize* goals sheet to set goals. Create 2 copies; retain one for your case file.

Towards the end of the session, take a five to ten minute break (you will have prepared the couple for this at the beginning of the session). Use the break to organize your thoughts, to reflect on what has occurred, and to plan the tasks.

Example of what to say:

“We’re nearing the end of the session and I’d like to take a five-minute break. This is to give you time to think about what we have discussed, to pick out any important ideas that came up, or to make any decisions or plans. You might think about the best outcome that could result from today. While you’re thinking I will summarize my thoughts, and gather resources that will be of most help to you. When we get back together, I’ll be interested to hear what stood out for you today. I’ll also share the team’s thoughts with you today. I’ll also share the team’s thoughts with you. Together, then, we can put something together that will be helpful.”

Experiments/tasks are suggestions for them to try, not assignments they are commanded to do. They should be suggestions that flow from where they are to where they want to be. *Use the break to summarize the session, and note the strengths of the couple*. Be sure to note these strengths once you rejoin the couple – compliment them!

‘Experiments’ (assignments) are designed to:

- Introduce change to the situation
- Encourages a spirit of experimentation
- Encourage clients to take an active part
- Evoke resources
- Highlight and allow follow-through on something that happened in the session
- Encourage the client to put more attention on an issue
- Encourage the client to take the next step before the next session
- Enhance the client’s search for solutions

Before session ends:

- Write down at least 2 ‘experiments’ that the couple is going to try out (can include referrals).
- Give each person Mi (‘About Your Experience’) and N (‘About Your Consultant’).
• Try to give the couple at least 1 handout related to their experiment, and give about 3 in total for them to use during Session 1 and 2. You may give more if they’re interested.
• MAKE AN APPOINTMENT TO MEET IN 3-4 WEEKS!

After session:
• Include in your case notes the experiments that you and the couple have created.

Solution-Focused Techniques:

Consider using scaling questions to help solidify the goals and resolve any concerns:

*Hope:* “On a scale from 1 to 10, 1 being absolutely no hope and 10 being complete confidence, what number would you give your current level of hope? What will tell you that your level has gone up a level? What number will be high enough to warrant you working hard to try and change things?”

*Motivation:* “On a scale from 1 to 10, 1 being no motivation and 10 being a willingness to go to any lengths to solve your problems, what number would you give your current level of motivation? What will cause that level to go up one level?”

*Compliment*

*Using the assessment* as well as session data, use compliments to validate the clients’ point of view, affirming what is important to them, their successes and strengths.

What to do if you hit roadblocks? What if the client...

a. **Can find and amplify exceptions:**
   ‘Between now and the next time, I would like you to continue to do more of this.’

b. **Can find only small differences:**
   ‘Between now and the next time, I would like you to look for times when these good things happen (the exceptions).

c. **Identify potential (not actual) exceptions:**
   ‘Between now and the next time, I would like you to look for times when you are doing something different’

d. **Struggles to find any possible differences:**
   ‘Between now and the next time, I would like you to look for times when you might imagine something different happening’

Do more of what works
Any skills, behaviors, or thinking the client reports that he or she knows how to do and anything that will contribute to the client’s life getting better should be repeated and encouraged.

**Formula first-session tasks:** ‘Between now and our next meeting, notice what is happening that you would like to stay the same. I’ll ask you about these next time.’

Examples:

*The overcoming the urge task:* “Pay attention for those times when the two of you overcome the urge to (argue, return to the old problem, not look for positives in what the other is saying, etc.). Pay attention to what’s different about those times – especially to what you are doing to overcome the urge.

*Addressing competing views of the solution (without taking sides):* “I am impressed by how much both of you want to improve your relationship. I am also impressed by what different ideas the two of you have about how to do this – I can see that, coming from your different perspectives (back-grounds, families, etc.), you have learned different ways to do things... I (or the team) am (are) split on which way to go: both of you have strong ideas. Therefore, I (we) suggest that each morning, right after you get up, you flip a coin. Heads means that day you improve things the way (person A) suggests, and the other person goes along; and tails means you improve things the way (person B) suggests, and the other person goes along. And also – on those days when each of you is not busy being in charge – pay careful attention to what the other does that is useful, and how you help with that, so that you can report it to me (us) when we meet again.”

**Readiness for Change**
At this point you, a spouse’s level of motivation often becomes apparent, possibly falling into three categories: visitor, complainant or customer. The following addresses how best to handle each of these situations:

*Client is a Visitor*
It may just be that one of the spouses genuinely does not want to be there and is not interested in change. One way to approach this is to go with their resistance, including making plans so that they do not have to see you again.

Example: “We are very impressed that you are here today, even though this is not your idea. You certainly had the option of not coming today... I agree with you that you should do what is important to you. But it seems that perhaps you are also here doing something that is important for your relationship. There are probably important things you’re already doing to build and strengthen your relationship.”
• Use active listening to fully understand the client who may be a visitor. Say
detailed statements that demonstrate your full understanding. When you hear
strengths, note what you are hearing (e.g., ‘it sounds like you cared for her
when you did _____. How did you accomplish this?’)
• If you hear complaints or problems, again use active listening. As possible, ask
questions (e.g., what they might see if things were a little better).

**Client is a Complainant**

• No exceptions and no goal: “Between now and the next time that we meet, pay attention to
what’s happening in your life that tells you that this problem can be solved.”
• Exceptions but no goals: “Between now and the next time we meet, pay attention to those
times that are better, so that you can describe them to me in detail. Try to notice what is
different about them and how they happen. Who does what to make them happen?”
• If a client attributes the exceptions entirely to the other person’s actions: “Pay attention to
those times when your partner (relationship) is more the way you want. Besides paying
attention to what’s different about those times, pay attention to – so you can describe it to me
next time- what he/she might notice you doing that helps him/her/the two of you to be more
_______. Keep track of those things and come back and tell me what’s better.”
• If the clients view the problem as existing outside themselves but are able to identify random
exceptions: “I agree with you; there clearly seems to be days your partner (relationship) is more
_______. And days when he/she/ it isn’t. So, between now and the next time that we meet, I suggest the
following: Each night before you go to bed when you make your prediction for the next day,
think about whether or not your prediction came true. Account for any differences between
your prediction and the way the day went, and keep track of your observations so that you can
come back and tell me about them.”

**Client is a Customer**

• A clear miracle picture but no exceptions: “Pick one day over the next week and, without
telling anyone, pretend that the miracle has happened. And, as you live that day, pay
attention to what’s different around your house, so that you can tell me about it when
we meet next time.”
• High motivation but no well-formed goals: “I am very impressed with how hard you have
worked and how clearly you can describe to me the things you have tried so far to make
things better. I can understand why you would be discouraged and frustrated right
now... If this is a stubborn problem, I suggest that, between now and the next time we
meet, when the problem happens, you do something different – no matter how strange
or weird or off-the-wall what you do might seem. The only important thing is that,
whatever you decide to do, you need to do something different.”
Well-formed goals and deliberate exceptions: “I am impressed how much you want to make things go better between you and your partner, and that there are already times this is happening (give examples). I agree that these are the things you have to do to have the kind of relationship you want. So, between now and when we meet again, I suggest that you continue to do what works. Also, pay attention to what else you might be doing – but haven’t noticed yet – that makes things better, and come back and tell me about it.”
Session 2

This Session Includes Steps 4-5:
(4) Evaluate the effectiveness of the previous tasks; (5) Re-evaluate the goals.
Take a break about 1/2 hour before the session ends, as described.

1. Follow up on EXPERIMENTS (Tasks)

Look at the ‘experiments’ you wrote down in your notes.
Evaluate the effectiveness of a task. If there were improvements even for only a short time, they will be thoroughly explored:
- What was different?
- What did you notice that was different in yourself? In your partner?
- Scaling questions are a good way to evaluate this.

Progress: “On a scale of 1 to 10, where 10 is the day after the miracle, and 1 is when this situation was at its worst, where would you say things are today? On a scale from 1 to 10, 1 being when the problems were just before you made the call and 10 being the problems are solved and a thing of the past, what number would you give your current level of progress (where you’re at now)? What will tell you that you have moved up one level? What number will tell you that you have made enough progress in solving this problem so that you can consider it solved?”

Efficacy Questions

These are intended to call attention to client’s self efficacy – that is, their abilities to make a difference in the desired direction.

- How did you do that?
- How did you get that to happen?
- What strengths and resources did you draw on in order to effect the change?
- What was each of you doing differently when you were doing better (or when there wasn’t a problem, or when the exception happened)?
- How did each of you decide to do that?
- What would you say you (your partner) need to do to get that to happen more? What needs to happen first?
- What would your partner say you could do that would encourage him/her to do more of the things you think he/she could do to make a difference? Would you agree, even though it might be hard to do it or go first?

Highlight their progress
These questions are intended to highlight competencies, positive qualities, strengths and successes, and to weave them into the interpersonal context.

- What does that say about you as a couple?
- What else would you want your partner to know (or have him/her notice) that would tell him how much you (care or love him/her, are working hard, want the relationship to improve, etc.)?
- As you continue to see yourselves this way, how do you imagine things continuing to change for the better?
- How do you suppose letting your partner know you see these positive changes in him/her will contribute to the two of you continuing to make progress?

2. **Re-evaluate the goals.**

   It is important to adjust the goals to fit the client. If the situation deteriorated, the therapist will be interested in how the patient coped and hung on through the difficulties and what he or she did to stop the situation deteriorating further. It may be that there are considerable improvements the couple did not notice. Consider with the couple:
   - What differences exist now? (they may be very small, or perhaps growing)
   - What would be the next small sign of the change continuing?

   **If the couple set a formula first-session tasks:** ‘Last time, I asked you to notice what is happening that you would like to stay the same. What happened during the past weeks that you’d like to keep doing, or even build on?’

   The couple may use the assessment forms to demonstrate how they feel they’re doing. Some may be tempted to go into blame patterns for why it did not work. If so:
   - Give an empathic statement (e.g. ‘it must have been _ at that moment for you’). [Did you hear?]
   - Ask questions like
     - What might s/he have been feeling?
     - What was happening when this was different, or better?
     - Tell me, then, about times in the past weeks that this was different.
     - What were you doing (feeling) when things were at their best?

3. **Session Break and Closure**

   After ½ hour, take a break (prepare the couple for this at the beginning of the session).
Use the break to organize your thoughts, to reflect on what has occurred, and to plan a message (feedback and possible homework task) to be presented to the couple when the session is resumed.

Repeat previous steps discussed in Session 1 to develop new goals for the future.

Final Steps (last ½ hour):
- Be sure to have the clients complete the Post Assessment survey after session (waiting rm).
- Write down at least 2 further ‘experiments’ that the couple is going to try out (can focus on referrals).
- Give each person Mii (‘About Your Experience’ – this is the second one with the ‘before’ and ‘after’ questions) and N (‘About Your Consultant’).
- Give the couple further handouts related to their experiments for future use.
- Let the couple know that their consultation is finished, but...
- Offer clients further services if they would like, or to facilitate a referral for them.
- Educate them about relationship education opportunities and therapy opportunities.

After session:
- Include in your case notes the assignments or experiments that the couple would like to do.
Frequently Asked Questions

What if one partner doesn’t want to attend?
Call the person to identify and allay concerns. Listen – and listen actively.
‘So you’re put off by ____’ (or) ‘you think this could be hard or harmful because of ____’.
‘What are your concerns?’ ‘Tell me what would make things more comfortable.’

Once the person knows you understand or ‘get them,’ emphasize
• ‘This is consultation and education – it’s a bit different from therapy.’
• ‘It only takes 2 sessions, and it’s done.’
• ‘You’d be able to represent your experience points of view.’

It is important that both partners attend. You will see the circular patterns of interactions when you have both partners with you; this is not possible with only one in the room.

What if only one person attends?
After all efforts have been made to encourage both partners to attend, it is okay (but NOT preferable) for just one partner to attend.
• Collect data from both partners if at all possible – even if gathered later on.
• Follow the session format as outlined.

What if the couple wants further therapy?
Once they finish their two sessions of Revitalize, it’s great if the couple wants to do further work! They should be given referrals as appropriate (professionals, agencies, websites, books).

References


