EFFECT OF SOLUTION-FOCUSED BRIEF THERAPY'S "FORMULA FIRST SESSION TASK" ON OPTIMISM

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I am submitting herewith a thesis written by Rita M.H. Jungblom entitled "Effect of Solution-Focused Brief Therapy's Formula First Session Task on Optimism." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Psychology.

Stuart Bonnington, Major Professor

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Effect of Solution-Focused Brief Therapy's "Formula First Session Task" on Optimism

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DEDICATION

This thesis is dedicated to those who

have hit rock bottom only to climb to the top.

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I would like to thank my major professor, Dr. Stuart Bonnington for his guidance, light-heartedness, and positive outlook. Appreciation is also extended to the other members of my committee, Dr. McCarthy and Dr. Butler, for their input and assistance. Each of my professors at Austin Peay have played a vital role in helping me develop my skills as a researcher.

Heartfelt thanks is extended to Donna Schictel, Connie Kerboski, Lynn Tertechiny, Austin Peay's Child Learning Center, and Christ The King Daycare. Thank you for caring for my children as though they were your own and for providing me with peace of mind.

I would also like to thank my parents, Charles and Barbara Harpool, who instilled in me the importance of education and the power of positive thinking. Last but not least, I would like to thank my husband, Bill, for believing in me and supporting my goals and ambitions.

ABSTRACT

The Formula First Session Task (FFST) is a standard intervention used in Solution-Focused Brief Therapy. It is postulated that the FFST increases optimism. However, studies examining the effect of Solution-Focused Brief Therapy's FFST on optimism are limited and have produced differential results. The purpose of this study was to empirically determine the effect of the FFST on optimism. The sample consisted of 107 volunteers from undergraduate psychology classes. The experimental group (n=55) was verbally assigned the FFST as an intervention. A pre- and post-test, Optimism-Pessimism Scale (O/P), was employed to measure changes in optimism. The experimental group also completed the Additional Information Form (AIF) which indicated whether or not they complied with the assigned task and provided qualitative data. It was hypothesized that the FFST would increase the group's level of optimism. This hypothesis was based on the premise that the FFST heightens awareness of positive events occurring in a person's life, resulting in a more optimistic outlook. Contrary to expectation, the FFST did not significantly increase optimism as measured by the O/P. However, qualitative data indicated that the FFST did impact how participants viewed various aspects of their lives. Possible explanations and suggestions for future research are discussed.

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CHAPTER I

INTRODUCTION

In today's society people seem to be looking more and more for a "quick fix" or solution to their problems. In this fast-paced world, almost every aspect of society is trying to give consumers what they want: a product that is easily accessible, works, and is not time consuming. In some ways, psychotherapy is no different. Many clients do not wish, nor are they financially able, to remain in therapy for extended periods of time. In fact, Weisz and Weiss (1989) found that 50 percent of clients terminate by the fifth session and 80 percent complete treatment by the tenth session. Stern (1993) contends that managed care has also played a part in the recent popularity of brief therapy by mandating session limits and establishing dollar caps on mental health benefits. According to Norcross, Alford, and DeMichele (1992) the demand for brief therapies is expected to be on the rise over the next ten years.

Solution-Focused Brief Therapy (SFBT) originated in Milwaukee at the Brief Family Therapy Center in 1982 (Molnar & de Shazer, 1987). One aspect of SFBT that makes it so controversial is that it focuses on solutions and not problems. SFBT maintains that people have the resources they need to solve their own problems. The challenge is in assisting clients to recognize and carry out their own solutions. The basic premise of SFBT is that treatment can

be effective by focusing on solutions rather than problems, thus avoiding "problem talk."

There are many techniques implemented throughout SFBT in order to shift a client's focus from problems to solutions. The first technique is to assist the client in forming a well defined positive goal. To help identify an attainable goal, the therapist and client begin to explore exceptions. Exceptions are times when a little piece of the goal is already happening or times when the problem is at least somewhat manageable.

Clients who cannot identify exceptions or have difficulty developing a positive goal may benefit from the use of a hypothetical question. A typical hypothetical question used in SFBT is "If a miracle happened and you no longer had this problem, what would you be doing differently?" This sometimes enables clients to visualize the changes that would occur in themselves if the problem no longer existed. The client's response can lead to further exploration of exceptions and clarification of the goal.

A task is usually given to the client at the end of every session. The only exceptions to this are when the client does not believe the task fits or the therapist does not have one. The first session often ends with a standard task. This task, known as the "formula first session task" (FFST), was developed by de Shazer in 1984. The FFST is worded as follows:

> Between now and the next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your (life, marriage, relationship) that you want to continue to have happen (de Shazer, 1985).

The purpose of the FFST is to assist the client and therapist in forming a clearer picture of the intended goal and create a positive atmosphere for change. According to de Shazer (1985), the FFST promotes cooperation and optimism. However, studies which have examined the effectiveness of the FFST are limited. The FFST is only one component of SFBT but component analysis is important for treatment (Piercy & Sprenkle, 1990) and training purposes (Imber-Black, 1986). Since the FFST is a standard procedure used in SFBT it would be advantageous to conduct further research in order to clarify its purpose and impact.

CHAPTER II

LITERATURE REVIEW

Optimism

Optimism and pessimism have been associated with various areas of interest in clinical and health psychology. Dember, Martin, Hummer, Howe, & Melton (1989) found that optimism and pessimism are related to defense mechanisms. In 1991, Darvill and Johnson reported that optimism is related to extraversion and neuroticism. A person's health may also be affected by optimism. Chang, D'Zurilla and Maydeu-Olivares (1994) contend that lower levels of stress are correlated with optimism. Optimism has also been found to have a positive impact on a person's ability to cope and physical well-being (Scheier & Carver, 1985).

Optimism and pessimism have long been considered polar opposites. Today, that idea is being challenged in the psychological literature. Marshall, Wortman, Kunsulas, Hervig, and Vikers (1992) examined two instruments used to measure optimism and pessimism: the Life Orientation Test (LOT) and the Hopelessness Scale (HS). The results indicated that optimism and pessimism are multidimensional and should be measured separately (Marshall et al.). While developing the Optimism-Pessimism Scale (O/P), Dember, Martin, Hummer, and Howe (1989) expected optimism and pessimism to be highly correlated. However, a much lower correlation existed than had originally been expected. This

influenced Dember et al. to revise the O/P and create separate optimism and pessimism subscales.

There is still some question as to whether optimism can be altered. Is optimism dispositional or does it fluctuate depending upon the situation? One study that found optimism could be induced was conducted by Lewis, Dember, Schefft, and Radenhausen (1995). Lewis et al. attempted to manipulate levels of optimism via music, video tapes, and 60 positive or negative statements. The total sample size consisted of 118 undergraduate students. Subjects were randomly assigned to one of six conditions: 1) elating music, 2) depressing music, 3) elating video, 4) depressing video, 5) positive statements, and 6) negative statements. All three procedures were found to be effective in altering optimism in the desired direction (Lewis et al.).

Formula First Session Task

In 1985, de Shazer conducted an exploratory study on the FFST at the Brief Family Therapy Center. The FFST was given to 56 new clients upon completion of their first therapy session. During their second session, 89 percent of these clients reported positive things had occurred since the first session. Over half, 57 percent, stated that their situations had improved. Therapists claimed that clients who received the FFST were more optimistic and cooperative (de Shazer, 1985).

Adams, Piercy, and Jurich (1991) designed the first study to research the effects of the FFST. The study compared clients who received solution-focused therapy with the FFST to clients who received problem-focused therapy with the problem-focused task (PFT). The three treatment conditions were: 1) a problem-focused session with the FFST, followed by a solution-focused second session, 2) a solution-focused session with the FFST, followed by a problem-focused second session, and 3) a problem-focused first session with a PFT, followed by a problem-focused second session. Adams et al. were interested in how these three conditions would affect task compliance, ability to establish specific goals, and attitude toward treatment. The subjects were families selected from two clinical sites. A total of 60 families were randomly assigned to one of the above treatment groups. Each group completed approximately eight treatment sessions. Data was collected through the use of the Compliance Rating Scale, Pretreatment Status Form, Immediate Outcome Rating Scale, and the Termination Status Form.

Researchers found that families were more likely to carry out the FFST than the PFT. Families who were given the FFST reported significant improvement with regard to the initial problem and greater goal clarification. The level of optimism was not impacted by the FFST. Adams et al.

found no significant difference in outcome optimism between participants assigned the FFST and those assigned the PFT.

A study by Jordan and Quinn (1994) was conducted to determine if problem-focused and solution-focused therapies resulted in differential outcomes. Three of the dimensions that were measured were: 1) goal identification, 2) outcome expectancy (i.e. optimism), and 3) client's perceived problem improvement. Jordan and Quinn researched change on a small level by measuring outcomes after a single session. The sample consisted of 40 subjects who were participating in brief family psychotherapy. Participants were randomly assigned to either the problem-focused or solution-focused group. After completing one session of therapy, participants were given the corresponding task. The instruments utilized to collect the data included: the Working Alliance Inventory (WAI), Session Evaluation Questionnaire (SEQ), and the Handy Outcome of Psychotherapy and Expectancy Scale (HOPES).

Jordan and Quinn concluded that the level of goal clarity or identification did not differ significantly by approach. Outcome expectancy was significantly different. In other words, the solution-focused group had a more positive perception of therapy than the problem-focused group. Jordan and Quinn speculate that this difference is due to "solution talk" which emphasizes the good things that have already happened. Contrary to Adams, Piercy, and

Jurich (1991), Jordan and Quinn found that clients assigned the FFST were more optimistic about treatment outcome.

The results reported by Adams, Piercy, and Jurich (1991) contradict de Shazer's assertion that the FFST increases client optimism. On the other hand, Jordan and Quinn (1994) support de Shazer's assumption. The conflicting results of the above studies (Adams et al. 1991; Jordan and Quinn, 1994) indicate the need for further examination of the effect of the FFST on optimism.

This study evaluated the process of change on a microlevel. Specifically, it isolated the FFST and measured its effect on optimism.

CHAPTER III

METHOD

Participants

Participants consisted of 107 undergraduates from psychology classes at Austin Peay State University, Clarksville, Tennessee. All participants were recruited on a volunteer basis and provided written consent (see Appendix A). There were no limitations upon participation with regard to age, sex, or race. Participants were randomly assigned to either the control group (n=52) or the experimental group (n=55).

Materials

The Optimism/Pessimism Scale (O/P) was used to assess changes in optimism. The O/P was designed by Dember, Martin, Hummer, Howe, and Melton (1989). The O/P consists of two subscales which yield separate scores for optimism and pessimism. In 1995, the O/P was used in a study conducted by Lewis, Dember, Schefft and Radenhausen. Lewis et al. were trying to determine if optimism and pessimism could be experimentally induced. Subjects were given the O/P, the Multiple Affect Adjective Check List-Revised (MAACL-R), and the Wessman-Ricks Elation and Depression Scale (W-R). These forms were completed before and after numerous experimental interventions. These interventions included positive and negative self-referent statements, musical tapes, and video tapes. After analyzing the data, Lewis et al. found that the O/P was sensitive to mood

states. In other words, it is possible to detect temporary changes in optimism and pessimism by using the O/P after an experimental intervention. These findings provide evidence of construct validity for the subscales (Lewis et al., 1995). The test-retest reliability for the optimism subscale, given a two week interval, was .84 (Dember et al., 1989).

The O/P is a self-report instrument that can be administered to individuals or groups. It consists of 56 statements. Endorsement of 18 of the items implies optimism, 18 pessimism. The remaining 20 statements are filler items used to mask the intent of the instrument. Agreement or disagreement with each item is recorded on a four-point scale. A sample optimism item reads, "I expect to achieve most of the things I want to in life." A sample pessimism item reads, "The future looks very dismal." The instrument takes 8 to 11 minutes to complete.

The Additional Information Form (AIF) was used to collect qualitative data. It is a self-report form consisting of two questions and a rating scale (see Appendix B). The first question requires respondents to indicate whether they complied with the assigned task by circling yes or no. Respondents indicated how beneficial the task was to them by completing a five-point rating scale. The last question requires a written short answer allowing

respondents to elaborate on how the experience was helpful. This form takes approximately 1 to 2 minutes to complete.

Procedure

Students in undergraduate psychology classes were recruited to participate in the study. Participants were asked to read and sign the informed consent form. Each participant was assigned a number, written on a 3 x 5 card. Participants were then given the O/P scale. To ensure standardization, the researcher read the directions aloud as the participants followed along. Participants placed their assigned number on the O/P and completed the scale. The informed consent form and the O/P were placed in separate boxes by the participants. Anyone given an even number was verbally assigned the FFST by the researcher:

> "Between now and the next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your life that you want to continue to have happen."

All participants were reminded to return in one week to complete the second session. The researcher encouraged participants to have their 3x5 card handy for the second session.

Exactly one week later, participants completed another O/P and placed their assigned numbers on the form. All participants who were assigned the FFST also completed the Additional Information Form.

CHAPTER IV

RESULTS

The O/P was used to measure each participant's level of optimism before and after the intervention. Only data from participants who self-reported task compliance was analyzed (n=55). One participant indicated noncompliance. The repeated measures t-test was used to analyze the mean difference between the pre-test and post-test scores. The change in optimism was not statistically significant, $t(54)=-0.99$, $p>.05$.

Qualitative data collected on the Additional Information Form indicated that the FFST may have impacted participants in ways that were not detected using the O/P. Helpfulness of the task was rated on a Likert scale of 1 to 5 (1=not helpful at all, 5=very helpful). On average, the group rated the helpfulness of the FFST at 3.5. Additionally, responses to an open-ended question were collected. Participants were asked to explain how the experience was helpful to them. Responses were categorized according to common themes. Table 1 contains the various categories that emerged and frequency of response.

The largest number of responses fell into the "Positive Outlook" category which was comprised of responses which described a "positive" or "good" change in the way respondents viewed their future or current situation.

The category "Relationships" emerged as the second most frequent category. Responses included a heightened

awareness or observation of friends, family members, significant others, and God.

Answers categorized under "Life Evaluation" indicated that respondents had "re-evaluated" or "taken another look" at their lives. "Life Evaluation" responses were the third most frequently reported.

The category which included the vaguest replies was "General Observations." These responses simply stated that observations were made but specifics were not included. Responses indicating that the respondent had experienced a change of feelings were classified as "Feelings."

A few participants reported that they observed things that caused them to view themselves differently. These were categorized as "Self-Image." The final category, "Activities", consisted of one response which suggested the participant had observed various activities that he/she would like to do more often.

Responses varied in specificity but 84% of the participants reported changes or observations that impacted them. The remaining participants did not supply an answer.

TABLE 1

Categories That Emerged From Responses Indicating How The Experience Was Helpful

Category	n
Positive Outlook	15
Relationships	9
Life Evaluation	9
General Observations	6
Feelings	5
Self-Image	2
Activities	1

CHAPTER V

DISCUSSION

Although the inability to ensure task compliance is an admitted limitation of this study, the effects of noncompliance were minimized by only analyzing data provided by participants who self-reported compliance. This study was also limited by the fact that participants were not seeking therapeutic help. People who seek counseling may have lost sight of things in their lives they want to continue to happen. If clients observe things they did not realize existed, then the task may have an even greater impact on them. Participants in this study were probably aware of things they wanted to continue to happen before the task was assigned, thus the task may not have impacted them as much. Clients may also be more motivated to make and interpret observations in deeper, more meaningful ways in hopes that they will benefit from it.

The results of the study indicate that the FFST does not significantly effect optimism as measured by the O/P. However, the FFST does appear to impact the way people view various aspects of their lives. Whether or not this change can be classified as an increase in optimism is controversial. However, none of the participants rated the experience as "not helpful at all."

Further studies need to be conducted in order to better define optimism. There is also a need for the development of more optimism scales sensitive to temporary change.

Future studies should be conducted to clarify how the FFST effects people. One possible study would be to have graduate students, trained in Solution-Focused Brief Therapy, assign the FFST to clients seen during a therapeutic session. Qualitative data describing how clients perceive the helpfulness of the task could be collected. This information could guide future researchers in selecting an appropriate assessment instrument. These types of studies would measure the effects of the FFST within the context it is used, thus increasing generalizability.

Future studies might also assess possible change over a shorter or longer period of time. Various cultures should be included in research projects in order to document the effectiveness of the FFST cross-culturally. Another variable that may impact when the task should be used is chronological age. Various age groups need to be researched to identify ages that will benefit the most from the FFST.

In conclusion, the results of this study did not support the hypothesis that the FFST increases optimism. However, qualitative data indicated that the FFST does impact the way people view various aspects of their lives. Future studies need to be conducted to determine whether these observations significantly enhance the therapeutic process.

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APPENDICES

APPENDIX A

Informed Consent Statement

The purpose of this study is to examine the relationship between the way people think and the way they feel over time. Each participant will be required to meet with the investigator on two different occasions. You will be asked to complete a self-report form. This form will consist of 56 statements. You will rate on a scale (1 to 4) whether you agree or disagree with each statement. It will take you about 11 minutes to complete. The investigator may ask you to observe something in your life for one week. After one week the investigator will meet with you again for about 15 minutes. You will complete another self-report form, similar to the first one. You may also be asked to complete a second form. This form will consist of two questions and a rating scale. You will have to circle yes or no to indicate if you took time to make the assigned observation. You will be asked to scale (1 to 5) how helpful the experience was for you and to write a brief statement describing how it helped you. At no time will you be asked to write or talk about your observations. No identifying information will be written on any of the forms. At the end of the second meeting, the investigator will provide each participant with a participation form. Extra credit will be awarded at the discretion of the instructor. The scope of this research project will be explained fully by the investigator upon completion.

Your responses are confidential. No identifying information will be on any of the forms. This signed consent form will be kept separate from the questionnaires. No one other than the investigator will have access to your responses. There are no known risks involved in your participation. If you become uncomfortable while completing the forms or at any time during the research, you may terminate without penalty. If you have any questions or concerns, you may contact the investigator, Rita Jungblom, or my supervisor, Dr. Stuart Bonnington, Psychology Department, Austin Peay State University, (615) 648-7233.

Thank you for your cooperation.

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I agree to participate in the present study being conducted by Rita Jungblom, graduate student, under the supervision of Dr. Stuart Bonnington of the Psychology Department at Austin Peay State University. I have been informed, either orally or in writing or both, about the

procedures to be followed and about any discomfort or risks which may be involved. The investigator has offered to answer any further inquiries that I may have regarding the procedures. I understand that I am free to terminate my participation at any time without penalty or prejudice and to have all data from me withdrawn from the study and destroyed. I have also been told of any benefits that may result from my participation.

NAME _____

SIGNATURE _____

DATE _____

APPENDIX B

Participant's #_____

Additional Information Form

1. Did you take time during the past week to observe things in your life you want to continue to have happen? Circle one:

NO YES

2. On a scale of 1 to 5, with 1 being not helpful at all and 5 being very helpful, rate how helpful this experience has been for you.

1 2 3 4 5

(not helpful at all) (very helpful)

3. If this experience has been helpful to you, explain how.

VITA

Rita Jungblom was born in Louisville, Kentucky on October 17, 1969. She graduated from Corydon Central High School in Corydon, Indiana in May 1988. In 1992, she earned her Bachelor of Science degree from Indiana State University. As an undergraduate she majored in Criminology and her minor was Psychology. While attending Indiana State University, she worked as a Resident Assistant and as a Resident Hall Assistant Director. Upon graduation, she was commissioned a 2nd Lieutenant in the United States Army Reserves. She attended Officer Basic Course and served as a member of a Military Intelligence unit in North Carolina for 15 months. In 1994, she enrolled as a graduate student in the Clinical Psychology Program at Austin Peay State University in Clarksville, Tennessee.

She is currently completing her internship at Trover Clinic in Madisonville, Kentucky. She is interested in working with married couples, families, and children.