MEASURE WHAT WORKS:
A FOCUS GROUP INVESTIGATION OF THE SESSION RATING SCALE

by

Jennie Graff-Dolezal

A Research Paper
Submitted in Partial Fulfillment of the
Requirements for the
Master of Science Degree
With a Major in
Marriage and Family Therapy
Approved: 2 Semester Credits

Investigation Advisor

The Graduate School
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Abstract

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I am a person that has eyes bigger than her stomach, and wants to “save the
whales.” This combination of characteristics might not be the formula for success, but
with focus, advisement, as well as, support from friends and family great things can be
achieved. I have many people to thank:

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Chapter One

Introduction

What works in therapy? How do we as therapists know if the goals we are working toward with clients are being accomplished, according to the client? These are essential questions for therapists to be curious about in our work with clients. I find myself being appreciative of the previous researchers who have explored these questions at great length. I believe their work has yielded some encouraging results. At the same time, I am thankful I did not attempt to tackle these questions in my limited, semester-long investigation!

As a Marriage and Family Therapy graduate student, soon to be practicing therapy without the safety and support of four supervisors and eleven colleagues, I am relieved to know someone is looking into these types of phenomena (what really works in therapy??). I think it is important to explore these questions from different angles in order to better understand them.

One angle, in particular, that I am familiar with is that of student and beginning therapist. In these roles my task has been to learn new theories, and integrate them into my work with clients. The question that frequently comes to mind – one that I have often posed to supervisors -- is “What is the best model or theory to use with clients?” or, “Which theory connects it all together?” The response I repeatedly receive is that it is part of our work as students in The Marriage and Family Therapy program to explore and discover theories that fit with each of us and our unique style as therapists. Many of my colleagues have found their niche. They have fallen in love with a theory and successfully worked with many clients using that particular model. Then, there is me.
I have yet to feel at home with any one particular model. As I am fast approaching the end of my time in this program, the pressure is on. In fact, this entire practicum year I have been exploring and trying on different theories to see how they fit, but alas, not a one has been a good match with how I conceptualize my work with people.

When I read “Beyond Integration: The Triumph of Outcome Over Process in Clinical Practice” (Miller, Duncan & Hubble, 2004) I saw a glimpse of hope and freedom. This article, and the work of these authors, inspired me. I searched for more of their work on “what works in therapy” and was in awe of what I found. No one theory or model is the best (Hubble, Duncan & Miller, 1999)! Sure, there are certain theories that have been more researched than others, but the point that I literally took with me and ingested, was that there is not just one ultimate cure-all theory. I have not abandoned my search for a model that suits my philosophy as a therapist. Conversely, completing this project has helped me significantly in my search for an integration of personality, soul, and theory.

The beginning of my relief from anxiety came from reading the line, “...the client is the primary agent of change” (Tallman & Bohart, 1999, pp. 94). As I feverishly continued with my reading, I found that one of the most significant elements of therapeutic change is the relationship the therapist provides for and with the client. The relationship can be a “safe place” for the client to access their inherent self-healing and wisdom. “Great!” I thought, “I can handle that because I think I connect well with others, and I can provide that non-judgmental relationship.”
In reading more, I discovered that the success of therapy is not based solely on the therapist’s perception of their own ability to provide that safe, healing space. Instead, it is the client’s perception of that relationship that has crucial impact on the success of the therapeutic outcome (Hubble, Duncan & Miller, 1999). Upon gaining this knowledge, it appeared logical to dig deeper into the client’s experience of the therapeutic alliance. Once again, there have been multiple studies that have implemented methods of measuring the degree of therapeutic alliance, and that support the importance of connection between therapist and client (Hubble, Duncan & Miller, 1999; Lambert & Brown, 1996).

The next logical step in my own process was to explore the use of a valuable tool that emerged from research on change in psychotherapy, the Session Rating Scale 3.0 (SRS) (Johnson, Miller & Duncan, 2000; Miller, Duncan & Hubble, 2004). I wanted to explore whether this tool could be helpful, and start to understand its benefits to therapeutic change in the setting where I was learning. This is where previous research dropped me off at the starting point of my own research.

Prior to this project, my previous experience with research had been working within a quantitative framework. So, when I started to look into what I was curious about, my thoughts went directly to how to explore my ideas within a quantitative framework. When I had difficulty generating quantitative questions that I was genuinely curious about, it was suggested that I consider a qualitative exploration of how client feedback could inform the therapeutic process with clients. As it turns out, that is exactly what I did. I gathered feedback from therapists regarding their
experience using the SRS and how it changed the direction of the therapeutic process and alliance.

This study attempts to answer this question using a focus group methodology. This project is relatively small and exploratory in nature. Instead of tackling the big question, “What works in therapy?” I examined a measure that can facilitate therapeutic change as well as strengthen the therapeutic alliance.
Chapter Two

Literature Review

This study is an exploration of how client feedback changes the work of Marriage and Family student therapists at a specific location, the Clinical Services Center at UW-Stout. Because no previous research has been conducted regarding the use of this tool at this location, there were no studies to turn to for direction, or to replicate. However, there has been a large amount of research that examines process and outcome in therapy, as well as focus group methodology. This literature base has drawn on client feedback to help researchers understand therapeutic success. These studies are what I drew from in order to develop this project.

Process research examines the way change occurs by exploring in-session variables during the course of therapy (Hecherington, Friendlander & Greenberg, 2005). Some process researchers aspire to uncover the moment change occurs in therapy, as well as what precedes the change event. For example, a researcher would pay attention to specific behaviors that lead to hypothesized change mechanisms and study these behaviors to see how they function in process. This type of research contributes to therapeutic success by raising therapist’s awareness about what might facilitate change. Research that focuses on the process of change is inevitably linked to outcome as both are investigating improvement and progress towards meeting treatment goals.

Outcome research focuses on the amount and direction of change or the effectiveness of therapy. Commonly, outcome research pairs specific symptoms with effective treatment approaches. This type of research also assesses what clients get out of therapy, for example, if the client’s goals are met. Patterns of the degrees of
improvement in therapy are discovered from outcome research. It has been suggested (Miller, Duncan & Hubble, 2004), that data from outcome studies can be used to examine the effectiveness of current methods and treatment plans.

Use of the Session Rating Scale (SRS) (Miller, Duncan & Hubble, 2004) differs from both process and outcome research in that it is a clinical tool that therapists can use each session with each client, and it uses outcome as a guide to the therapeutic process. The SRS is a tool that measures the client’s perception of their therapeutic experience regardless of the therapeutic approach being used.

Miller, Duncan & Hubble (2004) developed SRS and from its use were able to evaluate the effectiveness of basic approaches to psychotherapeutic integration. The work of these authors yielded results that suggest that regardless of therapeutic approach, the success of therapy is largely dependent on four key factors. These factors are; client and therapeutic alliance, client/extra therapeutic factors, client’s frame of reference regarding the issue, and the therapist’s ability to adopt the client’s frame of reference as the theory for working together (Miller, Duncan & Hubble, 2004).

Their research also supports the argument that the best hope for success in therapy will come from listening to clients and using their feedback to guide future research. These authors argue that the psychotherapy industry will suffer unless practitioners integrate and focus on client feedback.
Session Rating Scale 3.0 (SRS)

The SRS is a four-item measure that assesses the aforementioned four essential common factors for therapeutic change (Johnson, Miller & Duncan, 2000). This measure is based on encouraging clients to identify issues related to the therapeutic alliance and process so that the clinician may change their approach to better fit client expectations. The four items that are measured are: (1) the relationship; the degree to which the client felt heard, understood and respected (2) goals and topics; the degree to which the client and therapist did or did not work on and discuss what the client had wanted, (3) the therapist’s approach or method; the degree to which the therapists approach is a good fit and works for the client, and (4) overall impression the degree that something was either missed in the session, or that the session was right and productive for the client (Miller & Duncan, 2000). The instructions that accompany the SRS are for the client to place a mark along a ten-centimeter line with more negative responses to the left and more positive responses to the right. Typically, the scales can take less than a minute for the client to complete and the therapist to score.

Additionally, the SRS is available in written and oral form as well as in several different languages.

The SRS is a client and therapist friendly tool that is easy to administer. Recent research has found that using a client’s feedback regarding the therapeutic alliance, as well as progress toward therapeutic goals, has yielded significant results including increased client retention and improved outcome (Miller, Duncan & Hubble, 2004). Moreover, according to Miller et al. (2004) clients that declined the opportunity to use the SRS in therapy were as much as two times more likely to not complete treatment
compared to those who did choose to complete the SRS! Further, those clients that did
not complete the SRS were three to four times more likely to have a negative outcome
in therapy.

The SRS has a high reliability, thus the results can be translated into trustworthy
findings. This scale has an internal consistency of $\alpha = .88$ (Miller, Duncan & Hubble,
2004). This high degree of internal consistency reflects the fact that the four items
correlate highly with one another. This might indicate that the SRS could be
conceptualized as a global measure of the client therapist alliance. The SRS has an
internal reliability of .74 (Miller, Duncan & Hubble, 2004). Because of the brevity,
ease of administration, and scoring, the SRS has good face validity, which is typically
missing from longer and more technical measures that seem distant from the client's
experience (Piercey & Nickerson, 1996).
Chapter Three

Methodology

This study was a qualitative focus group examination of therapists' experience in using the Session Rating Scale (SRS) at a college campus mental health clinic. It attempted to explore the experiences of therapists, their perception of clients' use of the SRS, including its effect on clients' progress and investment in therapy. This study also attempted to gain knowledge for how to improve the implementation of this tool for greater ease in future use. In this study, I wanted to explore therapists' experience using the SRS if and how it changed the direction of the therapeutic process and alliance.

Qualitative Methods

Qualitative research has been employed in the social sciences for many years providing descriptive, interpretive, naturalistic and discovery-oriented methods of examining a multitude of theories and situations (Hubble, Duncan & Miller, 1999). Qualitative studies tend to be "discovery oriented" and generally focus on the exploration of meanings and perceptions of different experiences. Qualitative research tends to yield descriptive data (Taylor & Bogdan, 1998). In qualitative research, direct observation is often the means of gathering data. Further, qualitative researchers often go into the setting or into the "field" and immerse themselves in the phenomenon which they are studying (Mahrrr, 1988). This immersion can be accomplished by interviewing participants about their experiences, observing them in action, conducting a focus group or by becoming part of the situation and recording participants' impressions or all of the above. In this study, I chose to be a participant in the study as well as have a dual role in the focus group such that I was the facilitator as well as a
participant. Given that I too was a therapist in training at the Clinical Services Center and have administered the SRS in my work with clients, I was a participant observer in this project. Acting as facilitator and participant of the focus group, I added input to the conversation as well as introducing new questions when the group had exhausted their responses to a prevailing question. During the process I took notes on participants' responses and feelings. Later the same day, I viewed the videotape of the group and took notes a second time. Five days later I reviewed the videotape again and added on to the summary I had previously compiled. The following week I reviewed the videotape again, starting with a blank sheet of paper instead of adding to the previous notes I had taken. Then, I compiled the previous summaries and my new notes. Finally, I reviewed the videotape in order to record specific quotes from some of the participants. Reviewing the videotape multiple times strengthened the credibility of the results by insuring I had a clear understanding of the themes presented by the group (Piercy & Nickerson, 1996).

Focus Group

Focus groups are not limited to or organized by one philosophical assumption. Conducting a focus group is an eclectic and creative approach to qualitative research that is growing in popularity. Current research (Wellner, 2003) suggests that focus groups are less clinical, more like real life, and are more revealing compared to traditional experimental interviews. Similar to ethnographic approaches to create focus groups attempt to create situations that are like real life. Focus groups provide observational measures, and have the potential to be less reactive than self-report measures frequently, participants might even forget they are being videotaped and their
behaviors being measured (Piercey & Nickerson, 1996). Wellner (2003) supports this idea by stating that research companies from Cleveland to Denver to Lancaster are conducting focus groups in settings such as living rooms, playrooms and even a bar setting in order to assist participants in feeling more comfortable, thus obtaining more useful information. For example, in my exploration the participants of the focus group gathered in the processing room of the Clinical Services Center on campus where the therapists congregate daily to meet and talk about their lives and/or clients. This was, in part, an attempt to capture the therapists' experience in a setting they were familiar with and presumably comfortable disclosing in. I wanted to utilize a focus group methodology in order to gain a better understanding of how the SRS was affecting the therapists at the Clinical Services Center and their work with clients.

Sample Selection

The participants in this study were volunteers. The selection criterion was strict and limited. In order to participate, participants had to be student therapists at the Clinical Services Center, enrolled in their second year, second semester of the Master's program in Marriage and Family Therapy at UW-Stout; they had to have used the SRS more than three times. With this rather strict criterion in place, seven of the twelve therapists who had been invited chose to participate. The size of my focus group was seven participants, which according to Piercey and Nickerson (1996) is within the limits of a standard group, large enough for a potential variety of responses and small enough that each participant can have a voice.

After approval of the study, I informed the therapists in my cohort of my intended project and asked that they be aware of their use of the SRS at the clinic. I
wanted to make sure to include therapists that had some familiarity with using the SRS in order to increase the variety of responses and reactions and get a broad range of experiences and therapeutic styles.

All of the therapists were middle class, white, with an age range from 25 to 58. There were six female participants and one male participant. Each therapist had used the SRS multiple times during the previous semester in their therapy sessions at the Clinical Services Center, and a few had used the SRS off campus at other practicum sites.

Data Collection and Analysis

Participants were initially solicited during a meeting on campus and given the date the focus group would be held. On the date of the focus group, the purpose and procedures of the study were explained to the group and informed consent was discussed and obtained. All of the participants stayed for the entire focus group lasting approximately one hour. None declined participation after reading and signing the informed consent form. I answered any questions the participants had about the procedure of the focus group and explained the purpose of my study.

The focus group took place on campus in one of the rooms of the Clinical Services Center during a time when there were no clients being seen at the clinic. The focus group was videotaped for viewing at a later time in order to assist in data analysis. I facilitated the focus group, and informed the other participants that I would contribute to the conversation with their permission, and all agreed.

The focus group was semi-structured in that I had a set of questions to ask the group. However, a point was made to maintain fluid conversation. When the group of
participants came to a conclusion, or the conversation lulled, I introduced another question. Thus, the conversation was tailored to the interests and experiences of the participants.

The questions that structured the focus group were:

- Describe the client population you administered the SRS to in your work.
- What were the client’s initial reactions to the SRS?
- How comfortable were you in administering the questionnaire?
- How, or in what ways did that influence your use of it?
- Did the questionnaire influence the direction of therapy? If so, in what ways?
- How or in what ways was the client’s participation or investment in therapy influenced?
- In your experience, are there certain clients that respond better than others to the SRS? If so, who are they?
- What did you learn from using the SRS?
- Would you recommend continued use of the SRS at the Clinical Services Center? Why or why not?

I transcribed the videotape and offered the transcript to the participants of the focus group, but none requested a copy. Commonly, in qualitative research, researchers are looking for patterns or themes that are present in the conversation (Mahrr, 1988). Data analysis was based on the use of some cut-and-paste methods in order to reduce and analyze the wealth of information that emerged from the focus
group (Stewart & Shamdasani, 1990). In this study, I was looking for themes that appeared in the discussion of each question presented to the group (Taylor & Bogdan, 1998). Comments were compiled by themes, and responses that were not significant to the purpose of this research were discarded.

Data triangulation can be helpful in the process of generating credible hypothesis about the themes that are present in the data pool (Gable & Hendrickson, 1995). Triangulation can be a way to crosscheck information and conclusions drawn from the data pool. Data was recorded on a common chart for simultaneous examination and comparison. Through this process the researcher has a greater likelihood of identifying the most powerful themes in the data (Maggs-Rapport, 2000). Data triangulation is also a way to use multiple data sources to help understand themes and phenomena that might be present. Two sources that were involved with the data in this project were the videotaped responses from the focus group, as well as my own responses and participation in the group.

Data from qualitative studies can be generalized based on the specific situation or phenomenon that is being studied and its’ similarities or differences to the situation in which it is being applied (Hubble, Duncan & Miller, 1999). Moreover, generalizability of the results is, in part, in the hands of the readers of the study and their judgment of the relationship between the situation and the data presented. The results yielded in this study may not generalize to participants in any other clinical setting. These results are informative for the specific use of the SRS at the Clinical Services Center at UW-Stout, but could potentially apply to similar educational settings.
Ethical Concerns

One ethical concern is associated with me, the primary researcher, being a member of the focus group. There is a possibility that the focus group participants’ responses may have been skewed as a result of my participating in the group (Patton, 2002). Participants may have wanted to be helpful and to give responses that supported the use of the SRS. Conversely, group participants may have not spoken up about their dislike of the use of the SRS in order to avoid hurting my feelings.

Simultaneously, my presence was helpful as I was able to answer questions that group members had regarding the SRS, which was an aid to responding to some of the questions about future use of the SRS at the Clinical Services Center. Further, at the Clinical Services Center the therapists perform co-therapy, and I was part of some of the co-therapy teams that used the SRS. Thus, my co-therapist’s and I had, from my perception, valuable information to contribute to the group. Also, my co-therapists gave feedback that they appreciated my presence. Their responses were that I contributed to their recall of interactions with clients and gave different perceptions of our experiences with the SRS. The possibility exists that my participation may have provided more insight and strength to the overall responses.

According to Johnson (1997), a researcher’s ability to be actively aware of and reflective about their potential biases is the researcher’s reflexivity. Throughout the process from creating the plan to reporting the results from this exploratory study, I have been constantly reminded to pay attention to my own biases and preconceptions.
Researcher Bias

My background consists of very limited clinical experience. For the past year I have been working with people in an outpatient hospital setting as well as at a clinic on a college campus. This might affect my research in that I lack experience in these types of settings. Another view is that my bias might be to look at possibilities within the research findings because I do not have a framework set in my thinking about how or what therapy is supposed to look like. In order to account for my lack of clinical experience, I consulted with a few experienced practitioners and turned to previous research for guidance.

My prior experience with research has been within a quantitative framework. This past research might affect the present project in that this project is working from a qualitative framework, which is, in my experience more experiential and in depth as compared to the removed standpoint of my previous quantitative research. This type of work is new to me and I am learning from my supervisors and suggested readings how to work within a qualitative model.
Chapter Four

Results

The data from the focus group was surprisingly straightforward. Definite themes were present in the group's responses to the questions presented to them. The results were analyzed by utilizing a mix of models. I viewed the data multiple times, and compared themes to one another that I gathered from each viewing.

The client population the therapists administered the SRS to was for the most part individuals; however two families and three couples also used the SRS in their work. The client's were white their genders split, approximately half male and half female. The client's ages ranged from late teens to individuals in their 50's.

A main theme did not surface regarding the client's initial reaction to using the SRS in therapy. Some participants reported that the client was confused and possibly felt like they (the client) were grading the therapist. Further, the therapist observed the possibility that if the client were "grading" the therapist on their work that the client would not want to upset the therapist by giving them low marks. Other participants described the client's reaction to be somewhat of a power shift, "now I'm (the client) in control."

Another participant expressed that other responses were flippant or possibly rooted in embarrassment about the therapists potential response to the client's feedback. Yet, some participants reported a reaction of gratitude that linked to the thought "they (the therapist) really care about me and what we are doing." Finally, some clients were taken aback by the therapist's interest in the fit of their relationship.

Participant A: "One client I had said that they had never had a therapist ask them
a question like that, like about how the therapist was doing their job to help the client out!"

Most of the participants reported that they were uncomfortable using the SRS in paper form for a multitude of reasons. Participants spoke of how they experienced different forms of discomfort in starting to use the SRS in therapy.

Participant C: "I didn't like handing over a sheet of paper because I think it contributed to the clients feeling like they were grading us, and in turn, I kind of felt like I was!"

Another common response spoke to the amount allotted to a therapy session and the pressure to get everything in.

Participant B: "The end of the session feels rushed anyway, and to add one more thing to do is too much."

Additionally, the importance of time is associated with processing the feedback with the clients.

A unique response from one of the participants was regarding her particular approach to working with clients,

Participant A: "I feel like I never know when the session is over, because I don’t think it is up to me, I think the client and I come to a safe spot to end on the client’s time, so I had a hard time deciding when to use it."

This comment speaks to how the SRS works with different models and approaches to therapy. A consensus was reached that being conscious of the time and stopping with plenty of time to use the SRS would be the most ideal situation.
Other participants reported that they received high marks consistently and felt “greedy” asking the client to complete the SRS at each session. In sum, a clear theme exists that the more uncomfortable the therapist was at using the SRS the less likely they were to use it.

The participants did report that when they asked the questions from the SRS verbally, the client’s reaction and responses were more accepting and involved.

Participant E: “When I asked the clients these questions verbally instead of handing them something to fill out, I received more information and then, if the client didn’t totally understand the questions I could help them have a better grasp of what we were trying to get at.”

From this part of the discussion, one potential downfall the group agreed upon was that the clients might not be as honest about their feedback when the SRS was used verbally because it may seem more intimidating than simply making a mark on a paper.

The participants came to a consensus that generally, the SRS increased the client’s investment in therapy.

Participant B: “After the client understood the purpose of the tool they seemed to soften and be glad that I wanted their input. It made working together more of a partnership.”

In addition, the use of the SRS can help to establish the relationship between the client and therapist and build trust that the therapist will stick to their word. The participants also reported that the use of the SRS can increase client’s “responsibility” for their own work in therapy.

Participant F: “If they are having something they really need to talk about, they
know there is a set-up to bring it up.

Thus, clients have a built-in safeguard to help the therapist know what they need to work on and grow with in therapy.

The focus groups as a whole agreed that there are potential situations that the SRS might be more of a challenge to use than others. For example, the majority of participants felt that there might be some clients that would not respond well to using the SRS. One population the focus group suggested might not respond well to the SRS was individuals working with borderline personality difficulties. Another participant suggested that the SRS might be difficult to work when using certain theoretical models of therapy. Models that were suggested would not fit were dialectic behavioral therapy and strategic therapy because of the power and structure of how these models view client-therapist relationships. Another concern was when working with large families. One of the group participants had an especially positive experience with a family and the SRS.

Participant C: “At the end of the session, when it was time to use the SRS, it was the first time in that session that the entire family worked together to provide feedback. They all discussed how each individual felt and came to a family decision. Just being a witness to that gave me as the therapist so much information about that family!”

In couples work, a few participants reported that they gained a lot of information regarding who felt they were being heard and who did not by using the SRS. In one case, a participant shared their experience in which the husband and wife completed the SRS separately.
Participant E: "I gave each of them a sheet to fill out and then when I saw that the husband felt like his goals weren't being met but the wife thought hers were, we had a discussion about how to work with that. After that session, the husband was more active in the following sessions."

As evidenced by the participants' comments, the overriding theme of this discussion for the group was that no matter the model, using the SRS provides information and opportunity.

The focus group participants reportedly discovered that clients struggled with or were perceived to struggle with the first question regarding the quality of the therapeutic alliance. One participant told of an instance with a particular client regarding this question, where the client divided up the relationship question into three parts. The question, "did I feel heard," got a different rating that each of the other two questions, "did I feel understood," and "did I feel respected."

Participant C: "This client told me that she couldn't answer the question as it was because she felt understood and respected, but she didn't really feel like I heard her. So, we gave separate ratings to each part of the question, and I had the chance to learn about how to hear her voice."

Thus, another benefit the participants saw with verbally doing the SRS was that the question could be delivered in a way that fit the therapeutic relationship.

Additionally, this can be evidence to the general theme that using the SRS provides opportunity to gather information and strengthen the therapeutic alliance.

The group of participants concluded that they had learned many things about themselves while experimenting with the SRS. One common theme in the discussion
was that the therapist must be committed to using the SRS as a process of therapy consistently to get the full benefit of it as a tool.

Participant A: “Now that we have been talking about using the SRS I wish I would have been more dedicated to using it because it has so much potential.”

Further, the participants highlighted the importance of how the therapist viewed the questions on the SRS. Consequently, it is essential for the therapist to remember that the SRS is not a rating of the “me” (the therapist), but of the session.

Participant E: “I found that when I remembered and framed it for the client that this was about our work together and not be getting a good grade or mark of approval from you (the client), I was more comfortable with using the SRS.”

An associated theme that emerged from the focus group was that the SRS is a tool or method for creating some structure that is beneficial for facilitating checking-in with the client on the progress of their work together. For most participants, the SRS provided a way to ask questions that they realized were important to ask, and given a structure to do so made it easier to accomplish.

Participant D: “As I used the SRS with different clients I saw the difference it made for myself in paying attention during the session to things I thought I would be asking them about. My motivation changed because I knew I would be asking their feedback which has the potential to be awkward, but the SRS was a good way of checking in on what we were working towards.”

Also, once the participants had used the SRS a couple of times with the same client, both client and therapist anxiety seemed to dissipate.
The focus group unanimously endorsed the continued use of the SRS at the Clinical Services Center. In fact, the group went as far as to say using the SRS should be an expectation at the Clinical Services Center given the same importance as keeping up on paperwork. Also, part of new therapist orientation at the clinic should include being trained on the use of the SRS as well as some literature as to how it can be useful in therapy.

Some logistical suggestions were made for the SRS and its use at the Clinical Services Center. Mapping out the client and therapists' progress from one session to the next in the client's file was one suggestion. This way, clients could visually have a representation of how their work together is progressing. Another idea offered was to shrink the SRS down in size in order to seem less like another paper to fill out, but more as a reference to use. Finally, a suggestion was made to post a SRS scale in each therapy room at the Clinical Services Center so that the clients and therapists were aware and reminded of its importance and use.
Chapter Five
Discussion

Assumptions

It was assumed in this study that all participants were honest regarding their use of the SRS during their sessions at the Clinical Services Center. Also, I assumed that the therapists introduced the SRS and provided feedback as suggested when working with clients as it was impossible for me to view each administration of the SRS in session. Moreover, it was assumed that the participants were competent in reporting their own perceptions as well as the clients’ perceptions regarding the SRS.

Strengths and Limitations

A major strength of this study is that it was quick for the participants and cost effective for the researcher. Focus groups, in general, thrive on the creative and thought sparking nature of group discussions (Stewart & Shamdasani, 1990). Thus, there is plenty of room for respectful, idea generating, and motivating conversations to occur. Besides all that, people who have experience with what the researcher is studying bounce around potential novel ideas about the topic of the focus group.

Since the purpose of this study was to gain information about the experience therapists at the Clinical Services Center had with the SRS, the methodology of the focus group fit the task, and this is a design strength. Further, the participants in this study all were an excellent sample being that each participant had experience using the SRS as well as worked in the specific setting I was exploring. Piercy and Nickerson (1996) state the numerous advantages to a focus group and these apply specifically to this study: the setting is naturalistic, the facilitator is allowed to explore responses for
more information, can address a diverse range of questions, and finally (and arguably most important to this researcher) the results generated are straightforward and easy to understand.

There are limitations to any researcher, and some particular to the use of a focus group. Group dynamics can limit participants’ responses that might be related to a fear of saying something new and being ridiculed or not understood (Welner, 2003). Additionally, the facilitator was also a participant in the focus group and may have unknowingly skewed the data.

Griffin and Hauser (1993) conducted a study that made a comparison between one-on-one interviews and focus groups. Their examination yielded results that suggest that, compared to focus groups, interviews produce more useful responses that contain new ideas and information. This is a concern that might be a limitation more of the focus group dynamic because in a one-on-one interview the facilitator or interviewer has more control and may have the ability to explore more fully the ideas that the participant brought forth.

Conclusions

As previously stated, there are some changes that should be considered regarding how the SRS is used at the Clinical Services Center that might make implementation more useful and less awkward. Additionally, there were mixed experiences regarding how clients received the SRS as well as how therapists felt about using it. In sum, the therapist’s experience of working with and using the SRS was helpful. The main theme in all of the responses was that regardless of the kind of rating a client-therapist was given by using the SRS, both the client
and therapist were learning about one another, strengthening their connection and trust in one another. Further, at the very least of all possibilities, the therapist was gaining information from the client about how they might possibly work better together. Can you go wrong using this tool?

**Recommendations**

The focus group participants suggested many different ideas of how to use the SRS in our work and learning with clients. One suggestion in particular that seems essential to the success of using the SRS is to make its use more of an expectation in our work at the clinic as opposed to a recommended tool. These suggestions will be proposed to the faculty and program director at UW-Stout and most likely considered.

Future research might include conducting continued qualitative studies. One might conduct a focus group of clients that receive services at the Clinical Services Center in order to gather information about their experience. This type of a study might be particularly interesting if, simultaneously, another focus group would be conducted similar to the study reported here, gathering information and responses from the therapists. In this respect, the researcher would literally have both sides of the story.

As a continuation of this study, I might be interested in connecting with the participants of this focus group in six months and again in one year. One could conduct another focus group or individual interviews in order to gather information about ongoing use of the SRS. A longitudinal study could explore the question: if, how and why these therapists are still using the SRS as a tool to inform their work.


