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ARTICLE

Language Analysis in Solution-Focused Therapy Training: Comparing Trainees with their Trainer

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When the question of expertise arises in the field of psychotherapy, many authors question whether it is achievable or not (Hill et al., 2017; Shanteau, 1992; Shanteau & Weiss, 2014; Tracey et al., 2014), and some ask how to characterize it (Levitt & Piazza-Bonin, 2016; Norcross & Karpik, 2017). Ultimately, we need to know what specific actions are performed by an expert psychotherapist (Hill et al., 2017); the importance of research on expert psychotherapists does not reside solely in establishing the effect that experience has on clinical performance. Experts are also models who teach and supervise new psychotherapists (Hill et al., 2015; Hill & Knox, 2013). Therefore, we need to look more closely at what psychotherapists do.

The available research presents some contradictions. Eells et al. (2005) compared the quality of their case formulation of novices with less than 1000 hours of supervised practice, *experienced therapists* with more than 10 years of practice, and *experts*, who had more than 10 years of experience and were also recognized through their publications, manuals, or workshops. The ratings of the formulations by the experts were better than for the novices and the experienced therapists but, surprisingly, the ratings of the novices were better than those for the experienced. In the Witteman et al. (2012) study, the master's-level student group was better in a diagnostic task than practicing counsellors. However, research in the outcomes of actual psychotherapy treatment has found no significant differences due to experience (Okiishi et al., 2003; Okiishi et al., 2006), with outcomes for experienced therapists even becoming poorer in a longitudinal design (Erekson et al., 2017; Goldberg et al., 2016).

Along with this, the results of the meta-analyses are also inconclusive. Walsh et al. (2018) does indicate that greater experience goes hand-in-hand with greater effectiveness. However, previous meta-analyses yielded results indicating that greater experience brings about less effectiveness (Hattie et al., 1984; Weisz et al., 1995), or that the two variables are not related (Berman & Norton, 1985).

Something that all these studies do have in common is that they have not investigated process variables as use of language (i.e. verbal behavior, communication skills, helping skill, interpersonal skill). According to research, a high level of interpersonal skill (which points at being capable of making clients feel comfortable and understood, thus facilitating the dialogue) is connected with obtaining good clinical outcomes (Anderson, Crowley, et al., 2016; Cuijpers et al., 2012; Heinonen, 2014; Kadur et al., 2020), and can even be seen as an essential part of generating predictive models for success (Anderson, McClintock, et al., 2016; Schöttke et al., 2017).

These results are not surprising, after all, psychotherapy is a spoken profession (Isaacson, 2019), a conversation between at least two people. The psychotherapeutic context has, however, one characteristic that differentiates it from everyday face-to-face dialogue: therapists present an intentional use of language. This intentional use of language refers to the fact that, the theoretical knowledge causes therapists to modify some basic aspects of language such as the way in which they ask questions and the way in which they construct formulations in response to the client's content, highlighting certain aspects, ignoring others, doing so frequently or barely speaking (Jordan et al., 2013; Korman et al.,

2013; Tomori & Bavelas, 2007). For example, Huang and Hong (2015) found through microanalysis that skilled SF trainees (not less than five years of experience) used more complex formulations, opened questions and positive utterances than novices (less than 3 month of experience). MacMartin (2010) results indicated that solution-focused trainees tend to restructure their questions when an optimistic presupposition of improvement has not been accepted to make them more acceptable. Expert CBT therapists seem to perform more interventions with: new information, encouraging comments for the client, explanations regarding how the client's problem works, and greater authority, making direct requests to the client about the tasks to be performed out of session (Froján-Parga et al., 2011; Vargas-Cruz et al., 2014; Vargas-de la Cruz et al., 2018).

All these results should be taken as preliminary studies, since, as the authors point out in their studies, sample sizes and the descriptive nature of the research do not allow the generalization of the results. The differences found could be due to the therapist's experience, but also to differences between clients (their problems, their adherence to the treatment, etc.) or to the idiosyncrasy of each therapist (e.g. he/she could be more authoritative because of some personality trait, and not because of his/her experience) or they could be caused by the precise moment of evaluation. It should also be noted that none of the studies reviewed compared the level of responsiveness (Norcross & Wampold, 2018; Stiles & Horvath, 2017) based on experience, nor did they perform analyses that provide insight into the therapist-client interaction.

So far, the research could give the impression that language is an isolated characteristic of psychotherapists. Even the language-coding instruments developed tend to place more emphasis on the role of one (the therapist) of the (at least) two participants (Gumz et al., 2015). When research focuses on the therapist-client interaction, there is some evidence that the psychotherapist and client produce the dialogue together, such that it becomes impossible to understand what one does without taking into account the other, and vice versa (Peräkylä, 2011; Ruiz-Sancho et al., 2013; Stiles & Shapiro, 1995). However, at present we do not have enough evidence about the differences between experts and novices when it comes to client interaction and use of language.

We conducted an exploratory study on these interactions and whether they differ for trainees (or novices) and the supervisor (or expert). Since no consensus has been found on the most accurate definition of experience, expertise or expert (Hill et al., 2017; Norcross & Karpia, 2017; Shanteau, 1992; Shanteau & Weiss, 2014; Tracey et al., 2014), we have chosen a simple definition that facilitates grouping the participants through a questionnaire. Thus, in this study an expert is a person with more than ten years of experience working continuously as a psychotherapist. In addition to that, they must also be trainers or supervisors of new therapists. The definition of a trainee is a person who has two or less years of experience working continuously as a psychotherapist and who is in training at the time his/her performance is recorded.

The main reason for this study is to rethink the process of training psychotherapists. This research argues that by investigating the dialogue between therapists and clients, we may come to understand the process of therapy (Stiles et al., 1998). From this approach, this work aims to understand the differences in the use of language (process) between novice and expert therapists, to make improvements in training procedures. To our knowledge, this is the first such study conducted within a training program and this type of sample.

Method

The therapist-client interactions were examined in individual sessions where a novice therapist began the treatment, and an expert therapist continued it. This sample is selected with the intention of minimizing the alternative explanation to which the language used would depend on the case investigated. In this way, the client acts as a constant to investigate the use of the language of the expert and the trainees. The design of this study is observational and inter-subject, carried out in naturalistic settings. Descriptive analyses and exploratory hypotheses are performed as a first step toward the study of differences between experts and novices.

All participants had given their permission to be video recorded for research purposes. The Ethical review board (University of Malaga) approved the study and all ethical standards were followed (CEUMA: 14-2016-H).

Participants

There were six sessions, each with three participants: a client, a trainee therapist, and the expert. Sessions analyzed were of an integrative systemic model (Beyebach, 2009; Beyebach & Rodríguez-Morejón, 1999) that has solution-focused brief therapy as its foundation (SFBT; de Shazer, 1985), combined with techniques from MRI therapy (Fisch et al., 1982) and narrative therapy (White & Epston, 1990). Sessions are divided into two parts: an interview where client and therapist share information and an intervention where the therapist suggests homework or tasks; see Table 1 with descriptive data. The video-recordings of these sessions were selected from 23 sessions recorded at a Spanish private psychology center between 2012 and 2018. The selection criteria used to choose recordings were two: a) the expert, who supervised trainees and was viewing the session in real time on a monitor, entered the session to continue the treatment's first phase and b) when this happens, the conversation is entirely between the client and the expert, with no verbal contribution from the trainee.

Therapists

The expert was a male, 52 years old, with over 25 years of experience as a psychotherapist. He is a clinical supervisor supported by three professional Spanish psychotherapist associations. Moreover, he is the author or co-author of more than 20 book chapters and articles about SFBT. The trainees were six graduate psychologists with no prior experience in psychotherapy. At the time of collecting the data, they were in their second year of a three-year training program. In the first year of training, novice therapists received theoretical training on an integrative model of systemic therapy (Beyebach, 2009; Beyebach & Rodríguez-Morejón, 1999). They carried out at least 90 hours of specific technique practices (for example, miracle question, ineffective solutions, externalization) and basic interview skills (summaries, backchannels, open-ended questions, etc.). All practical skills are taught through a model where the expert performs the action for students to imitate, receiving constant feedback from their peers and teachers.

Clients

The sample is made up of four women and two men (their characteristics and the issues they presented are shown in Table 1). All clients received free treatment.

Data

All databases and extended tables can be accessed from the repository Open Science Framework (<https://osf.io/vstxj/>).

The continuous recording of language was divided into speech turns. These turns are the unit of analysis (i.e. the sample) of this research and are defined as: what the client says until the therapist speaks again and what the therapist says until the client speaks again. This includes all interjections used to maintain the conversation, such as “mmmh” or “alright”. The six sessions produced 3,672 speech turns; see Table 1.

Instruments

The SICOLENTE is a reliable and valid observational instrument (Rodríguez-Morejón et al., 2018) that consists in 20 categories with three dimensions: Conversational Act (7 categories), Therapeutic topic (6 categories) and Content (7 categories). It is used with psychotherapy samples recorded in audio or video, in which only the verbal aspect is coded. Each speech turn receives a unique code of three letters, a code for each dimension of the instrument (see Table 2).

Procedure

The codifications have been carried out by the main author of this research. To work with one encoder only, the analyst (AZ) was trained with the SICOLENTE manual. Then we decided to check the reliability of its encodings in comparison with a gold standard. The gold standard chosen was the coding sample performed in the intra-coder

concordance test of SICOLENTE development (Rodríguez-Morejón et al., 2018). This procedure implies, as Bakeman and Quera suggest (2011), the existence of correct and objective coding. According to the authors (Bakeman & Quera), an encoder was considered reliable if it obtained a .95 result in Cohen's kappa index. These data include the total number of categories (20), their equiprobability (it was agreed that all categories could occur with the same probability), and the high accuracy sought in the encoder (95%).

After obtaining these results, the search for recorded sessions that meet the aforementioned inclusion criteria was started. Speech turns were coded using LINC software (Gabín et al., 2012) configured with the SICOLENTE categories. The three dimensions of the instrument were used to code the data. Since the objective of the study is to investigate the therapist-client interaction, only the results obtained from the Conversational Act dimension will be reported. The complete data can be retrieved at <https://osf.io/vstxj/>.

Table 1

Description of The Sessions Analyzed

	Year	No. of session	Interaction ^{ab}	Observed sessions duration	No. of speech turns ^b	Problem
Trainee 1 Supervisor	2013	1 st	M-M	30' 39"	252-215	Drug abuse
			M-M	20' 10"	153-129	
Trainee 2 Supervisor	2013	2 nd	F-F	42' 43"	215-199	Couple issues
			M-F	10' 08"	62-48	
Trainee 3 Supervisor	2013	2 nd	F-F	28' 28"	109-94	Anxiety and social skills problem
			M-F	20' 24"	130-82	
Trainee 4 Supervisor	2012	1 st	F-M	33' 21"	279-221	Couple issues
			M-M	10' 29"	94-74	
Trainee 5 Supervisor	2015	1 st	F-M	26' 39"	201-138	Low mood issues
			M-M	16' 19"	161-111	
Trainee 6 Supervisor	2016	1 st	F-F	44' 16"	307-299	Low mood issues
			M-F	04' 17"	52-45	

^aM = male; F= female.

^bThe first is the therapist and the last the client.

Table 2

SICOLENTE Dimensions, Categories and Examples

Conversational Act	Therapeutic Topic	Content
Exploration (E)	Improvement (I)	Behavior (B)
Support (S)	Problem (P)	Thought (T)
New information (N)	Goal (G)	Emotion (E)
Exploration introducing new information (I)	Rules (R)	Physiology (P)
Comment (C)	Neutral (N)	Relationship (R)
Follow (F)	Mixed (X)	Mixed (X)
Reject (R)		Unspecific (U)
Examples		
1 Client: I've had a bad week...I was worried and I couldn't stop thinking about it		Follow-Problem-Thought
2 Therapist: It's good that you start to reflect on it		New information-Improvement-Thought
3 Client: I can't see it as good...I'm very overwhelmed		Reject-Problem-Thought

Note: Complete definitions of instrument categories can be found in the manual, published in Spanish and English at the online repository Open Science Framework (<https://osf.io/dyuz2/>)

Results

Two statistical analyses were planned: (a) comparison of proportions through Pearson's chi-square and two sample Z-tests; (b) one-lag sequential analysis through transitional probabilities (Bakeman & Quera, 2011; Escudero & Rogers, 2004). Following the guidelines set out by Bakeman and Quera sequential data was analyzed only when the row sum was at least 30 and the adjusted residuals were $Z \leq \pm 2.58 = p < .01$. This procedure is followed so as not to incur in an overestimation of the adjusted residuals and, therefore, a Type I error.

To perform both analyses, participants were grouped according to their experience. It is presumed that any differences that could be generated by clients are controlled since trainees and the expert have interacted with the same client.

It was observed in the descriptive analyses that the three most used categories by the novice and expert therapists are: *Support*, *Exploration* and *New information*, which constitute 90.2% of what the expert does and 91.8% of what the trainees do. The least-used categories are *Comment* (2.8% the expert and 2.5% the trainees) and *Exploration introducing new information* (7.1% the expert and 5.8% the trainees). Taking this all into account, the statistical test shows that there are significant differences between the two groups [$\chi^2 (4, N = 2015) = 24.292, p < .000$]. This indicates that this first global percentage is broken down differently for each group: the expert presented 25.5% of *New information* code and the trainees 17.4%. The *Support* code was encoded on 60.5% of the occasions for trainees, compared to 50% in the expert ($Z = 4.46, p < .01$).

To continue analyzing the results, the two main categories that handle common information with the client (*Exploration* and *Support*) and the two that introduce new information by the therapist (*New information* and *Exploration introducing new information*) were collapsed. Despite the fact that the expert spent less time in therapy session, the ratio of shared information/new information was $422/212 = 1.99$, while that of the trainees was $1012/316 = 3.2$. This shows that for approximately every two occasions in which the expert talks with the client using common information, he introduces new information on at least one occasion. Trainee therapists, in contrast, introduce a new information approximately every three occasions. This difference in the use of information is statistically significant. [$\chi^2 (1, N = 1963) = 20.289, p < .000; Z = 4.49$].

Client language was similar in both experience groups, with the *Follow* code used 99.8% of the time when talking to the expert and 99.1% when talking to trainees. The *Reject* code (which indicates client's disagreement with or clarification of what the therapist has said) has an extremely low appearance, accounting for only 0.2% of the conversation with the expert (only one occurs) and 0.9% of the conversation with trainees (12 rejections distributed in four of the six trainees, with a minimum of 2 and a maximum of 4 rejections per session). Table 3 includes descriptive data and the statistical analyses.

Finally, the differences between the expert and the novices are investigated taking advantage of the three-dimensional structure of the SICOLENTE. To do this, categories were collapsed to generate two new ones. The results by dimension indicate that the *Neutral* (46% for the expert and 52.8% for the novices) and *Unspecific* (57.7% for the expert and 58% for novices) categories are the most used in the Therapeutic Topic and Content dimension respectively. Since these two categories tend to appear when therapists perform backchannels, the idea was to investigate this element in depth. The triad of *Support-Neutral-Unspecific* codes ("of course", "aha", "I understand", "ok"), was called *Weak supports*, and all other *Supports* (except for the *Support-Rules-any category*) were called *Strong supports* (i.e. validate the problem, client goals or improvement; regardless of whether they are behavioral, cognitive, emotional, relational, etc. For example: "you're sad without reason, crying all day, alright"; "I understand, before you could be pessimistic too, but now you feel that you've lost something, right?").

Results indicated that there was a significant difference based on experience [$\chi^2 (1, N = 1146) = 23.304, p < .000$]. Trainees used more *Strong supports* than the expert and the expert more *Weak supports* than the trainees ($Z = 2.28, p < .01$) (see Table 3).

Regarding sequential analysis, only the trainee-client sequences were significant [$X^2 (8, N = 1212) = 73.17, p < .01$]. Three relational patterns were found. First, the *Support* code always activates the *Follow* code in clients ($Z = 3.10, p < .01$). The other two patterns indicate that whenever novices made changes of meaning (*New information* or *Exploration introducing new information*), this activated the client's *Reject* code (*New information* \rightarrow *Reject*: $Z = 2.85, p < .01$; *Exploration introducing new information* \rightarrow *Reject*: $Z = 3.78, p < .01$).

As indicated at the beginning of the previous paragraph, the sequential analysis of the expert with clients was not significant [$\chi^2(4, N = 489) = 2.40, p = .67$]. These results were expected considering that, in the contingency table, the combined frequencies of the Reject code for clients display 0 in four cells. This means that, given the testing requirements, statistical analyses cannot be performed. Despite the lack of statistical significance, describing the result is understood to be relevant: there can be no relational pattern with a code that does not occur, in this case, the rejection of the expert therapist (see Table 4).

Table 3

Differences in the Use of Language Between Trainees and the Expert Therapists

		Expert		Trainees		Z
		f	%	f	%	
Conversational Act ^a	Exploration	96	14.7	189	13.9	
	Support	326	50.0	824	60.5	**4.46
	New information	166	25.5	237	17.4	**4.25
	Exploration INI	46	7.1	79	5.8	
	Comment	18	2.8	34	2.5	
		$\chi^2(4, N = 2015) = 24.292, p < .000$				
Information ^b	Shared	422	66.6	1012	76.2	**4.49
	New	212	33.4	316	23.8	**4.49
		$\chi^2(1, N = 1963) = 20.289, p < .000$				
Support ^c	Weak	256	78.5	523	63.8	**4.81
	Strong	70	21.5	297	36.2	**4.81
		$\chi^2(1, N = 1146) = 23.304, p < .000$				

Note. ^a - INI: exploration introducing new information; only values that obtained significant test results appear in column Z.

^b - *Shared information*: all Exploration and Support codes were collapsed into this new category; *New information*: all New information and *Exploration introducing new information* codes were collapsed into this new category.

^c - The *Weak support* code is the triad SNU. The *Strong support* code consists of the following triads: SIB, SIT, SIE, SIP, SIR, SIX, SIU, SPB, SPT, SPE, SPP, SPR, SPX, SPU, SGB, SGT, SGE, SGP, SGR, SGX, SGU, SNB, SNT, SNE, SNP, SNR, SNX, SXB, SXT, SXE, SXP, SXR, SXX, SXU

* $p < .05$

** $p < .01$

Table 4

Sequential Analysis of the Conversational Act

	Expert		Trainees	
	Clients (targets)			
Therapists (givens)	Follow	Reject	Follow	Reject
Exploration	1	.00	1	.00
	0.48	-0.48	1.50	-1.50
Support	1	.00	1	0
	0.84	-0.84	3.48	-3.48
New information	.99	.01	.97	.03
	-1.55	1.55	-2.86	2.86
Exploration introducing new	1	.00	.94	.06
information	0.32	-0.32	-4.88	4.88
Comment	1	.00	1	.00

NI	NI	NI	NI
$X^2 (4 N=489) = 2.4, p = .67$		$X^2 (4 N=1167) = 32.12, p < .01$	

Note: The transitional probabilities appear first and below the adjusted residuals (Z). NI = The adjusted residues were not interpretable due to low code frequency. * $Z \geq \pm 2.58 = p < .01$

Discussion

To our knowledge, this exploratory study was the first to compare trainee-client communication and expert-client communication in actual therapy sessions with the same client. In this case, in addition to the treatment (all therapists are systemic), the client is constant for all therapists and that allows us to study the variables of interest (language and experience).

Results showed that the expert therapist performed more interventions intended to modify the clients' meaning than the trainees did, although he had less contact time with clients. Trainees spent most of the session performing summaries, exploring questions and using backchannels. Furthermore, when the trainees did intervene to modify meanings (e.g., using reframing, deconstructions or establishing new relationships with prior information), clients were significantly more likely to reject this change according to sequential analysis results.

An example of this can be seen in the following trainee-client interaction. The therapist is asking about client exceptions. Language between brackets indicates that both participants overlap when speaking:

- 1) T: One more thing Julian, we would like to ask if ... it ever happens that you... are there moments in your life when you feel closer to saying "hey, well, I'm close to feeling better, today I'm, like, a little more active, a little more positive"
- (2) C: No, I really never feel like that [and ...] I'm always negative like this...
- (3) T: [Never]

The novice therapist asks a question with a weak presupposition (using the conditional and asking a closed question) about the existence of moments of improvement. After the client's blunt response, the therapist did not explore these advances again; he accepts what the client has said through a formulation that presents an exactly preserved word (Korman et al., 2013). MacMartin (2010) found a similar response in the sample of systemic novices she investigated. Among the possible linguistic strategies, as in our trainee's example, some novice therapists in her sample simply accepted the client's disagreement with the presupposition and changed the subject.

On the other hand, the sequential analysis of the expert-client interaction did not present statistical significance. However, as discussed in the Results section, these data should be interpreted with caution. The chi-square test is not significant in this case because the low frequency of the *Reject* code prevents calculation in the expert-client interaction. However, the fact that this code does not appear indicates that practically all the new information suggested by the expert therapist was accepted by clients. Overall, the expert therapist receives fewer rejections than novices although he introduces many more changes of meanings (while the expert only obtained one *Reject* code from the client, novices accumulated up to 4 rejections in a single session).

We might therefore provide two suitable explanations for our results showing client refusals in the trainee-client interaction: they could be understood as evidence of the difference caused by experience, but also as a sign of a bad session seen by the expert, explaining why he decided to enter.

More detailed research is needed to understand how the new information-rejection interactions work, since this process could be helpful in shedding light on research with bad outcomes, but also on how the therapist reacts to these moments (Muntigl & Horvath, 2014). Especially for the model of brief systemic therapy that has been studied, being able to introduce changes, which the client does not disagree with, seems more positive than counterproductive. As Muntigl and Horvath (2014) indicate, these discrepancies compromise the therapeutic relationship and with it, the clinical outcomes; these would go to demonstrate that a proper collaboration between therapist and client is not being achieved (Bordin, 1979).

Regarding the supports, novices use more interventions to create therapeutic relationships and, in addition, the type of validations they perform are qualitatively different. Novice supports are longer, including more information such as behaviors, emotions or thoughts that they perceive in the client; these were known as *Strong supports*. Meanwhile, experts seek to validate with shorter interventions, more in the line of backchannels (yeah, right, uh-hum, okay); these were called *Weak support*. This can be understood again as part of a strategy focusing more on creating a therapeutic relationship, which seems characteristic of novices. This is perhaps related to the training they have received and have a hard time giving up in their first sessions. The expert therapist, guided by a strategy that focuses more on change, not only diminish supports, but he supported the client more concisely and with the objective of maintaining the

conversation. This does not mean that the expert stops making empathic comments or worrying about the therapeutic relationship; it could be that the lower frequency of *Strong supports* merely indicates that the expert knows how to differentiate when it is crucial to validate certain aspects, and which others can be omitted.

Lastly, another plausible explanation to our results is that the expert is not only being responsive to the client's needs but also to the previous trainee's performance. Given this, the expert's results could be elicited by both client and trainee. For example, differences in the language use (e.g., *strong/weak supports*, *shared/new information*) could be related to this reaction in the expert therapist to the previous dialogue between the trainee and the client.

Limitations

In order to carry out this design, with a constant client, some assumptions had to be accepted but these also imply limitations. Thus, this naturalistic study has implications for the sample and its external validity. We researched one psychotherapy model with just one expert. In addition, the small sample size detracts from the solidity of our conclusions and interpretations. Another limitation is that the sequential log-linear analysis used in the research assumes that what is important in dialogue is the relationship between the consecutive turns. In other words, we cannot easily analyze the context or track the accumulative effect of previous turns.

Conclusion

This study in a naturalistic setting makes the client a constant, while therapists change. This allows us to study differences in performance between novice and expert therapists. The results are:

1. Novice therapists make a greater effort to take care of the relationship, using more support and exploration maneuvers.
2. The expert therapist introduces more changes of meanings.
3. The expert therapist has a higher proportion of short supports (backchannels) than novices.
4. When novices introduce changes in meaning, they are more likely to be rejected than the expert.

Furthermore, this kind of analyses allows us to obtain a feasible feedback to use on training settings. According to our results, during the training an effort must be made to improve interventions directed to modify clients' meanings looking to obtain less refusals from them, since these interactions could probably correlate with disaffiliation and, therefore, treatment failure (Caspar et al., 2005; Muntigl & Horvath, 2014). This use of language is simple to teach; novices can be encouraged to introduce more changes and perform shorter validations to emulate the interaction implemented by the expert. When referring to teaching skills, procedures such as role playing, and modeling may be the most appropriate (Hill & Knox, 2013). The fundamental aspect in training is that novices may become capable of better adjusting to clients (Stiles & Horvath, 2017). Along with the use of language, training should seek to make novices feel effective and skilled, since all three aspects predict good clinical outcomes, especially in brief therapists (Heinonen, 2014, p. 64). In addition, it seems sensible to think that they are related: a greater sense of efficiency and skill in therapy, more attempts to change and introduce meanings and less insecurity about the state of the therapeutic relationship.

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