What is Helpful: The Client's Perception of the Solution-Focused Brief Therapy Process by Level of Engagement

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ARTICLE

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Abstract

The current study aimed to explore what elements from the solution-focused brief therapy (SFBT) process clients perceive as helpful and how their perception varies by level of engagement. The replication of the SFBT model from the perspective of clients residing outside the USA was also examined. A mixed-method design was used in a naturalistic setting in Poland. Clients (N = 346; 74% females) aged 18 to 67 attending psychotherapy in private practice were interviewed. Thematic analysis revealed eleven main themes. The SFBT-specific themes replicated the original model, yet a more ordered organization of core elements emerged than currently existing ones. The elements perceived as helpful significantly varied by the level of engagement. The two generic themes identified suggest that allowing the client to talk things out while working toward awareness and understanding is an essential environment in which the solution-focused co-construction process takes place.

Keywords: solution-focused approach, process research, client's perception, therapeutic engagement, Bruges model, mixed methods

Introduction

Solution-focused brief therapy (SFBT) is a co-constructed process that assumes clients are experts in their own lives and possess all abilities and resources needed to solve problems or overcome obstacles, though they may not be aware of this (de Shazer, 1985, 1988; Lipchik, 2011). The model was developed by Steve de Shazer, Insoo Kim Berg, and their colleagues at the Milwaukee Brief Family Therapy Center (BFTC) based on client's feedback regarding what helped them reach their goal (de Shazer, 1985, 1988; de Shazer & Berg, 1997; McKeel, 2012). SFBT is currently applied in a variety of cultures. A higher effectiveness was found for clients not residing in the USA, where it was first built (Neipp & Beyebach, 2022; Stams et al., 2006). Yet, no previous study was concerned with how much clients outside the USA perceived the helpfulness of the SFBT-specific elements.

Clients may perceive different elements as helpful according to their needs and expectations. Some clients may want to change; others may want to change others, while others may not know what they want. In line with client's engagement several types of relationships were identified within the SFBT model with the recommendation to adapt the intervention accordingly (de Shazer, 1988; Isebaert, 2016). Little research was concerned with providing empirical evidence for these recommendations.

The current study aimed to identify how much the elements of the original model were reflected in the feedback of non-USA clients and to explore how the perceived helpfulness of specific solution-focused (SF) elements varied by level of engagement. A naturalistic study was performed on Polish clients attending individual psychotherapy. The replication of the model can provide empirical support for its cross-cultural adequacy.

Studies on the client's perspective provide a different view of the therapeutic process than the one perceived by the therapist (Metcalf & Thomas, 1994), and thus offer additional information on how to shape the therapeutic process and adapt it to the client's real needs (Hodgetts & Wright, 2007). Given that therapy is a cooperative endeavor in which both the therapist and client play an active role (de Shazer, 1985), the identification of which element is more helpful for what client can help practitioners better tailor the intervention. SF trainers can further emphasize not only the method and questions but also their timing.

The Solution-Focused Process

The SF process is based on co-construction during which the therapist influences the way a client constructs his/her view of the problematic situation by choosing what questions to ask and to what responses to comment (de Shazer, 1985, 1988). Questions are directly based on the client's answer. Together they co-construct the aim of therapy, the preferred future, or de-construct exceptions to identify previous solutions or personal resources (de Shazer, 1994).

Specific questions or actions used by the therapist during the session were identified as core elements by the developers of the SFBT model: (1) Miracle question (asking the client to visualize how their life would be if a miracle would solve the problem), (2) Scaling questions (ratings of various aspects from 0 or 1 to 10 often used to identify progress and exceptions), (3) Break (the therapist stops interacting with the client often by leaving the room to prepare the feedback), and (4) End-of-session feedback (ending the session by complementing the client for their strengths and resources and giving suggestions or tasks to do after the session) (de Shazer & Berg, 1997). Suggestions are made in line with the SFBT central philosophy: i.e., repeat what already works, change what doesn't work, and don't fix what isn't broken (de Shazer, 1985). All four elements must be present to say that the SFBT model was used (de Shazer & Berg, 1997).

Later on, Gingerich and Eisengart (2000) added the Pre-session change (asking questions about the progress already happening before the first session) and split the Miracle question from Goal setting (establishing the aim of therapy), respectively the Scaling questions from Search for exceptions (exploring situations where the problem is absent), thus leading to three additional core elements. Yet, the new requirement for an intervention to be considered SFBT became "at least one element included" (Gingerich & Eisengart, 2000). These seven elements became a standard to use in research and practice.

Other authors proposed additional core elements such as Looking for strengths or solutions (identification of already possessed personal resources and strategies) (Kim & Franklin, 2009), Coping questions (investigation of how the client coped to look for strengths and solutions), and Focus on progress (examining what changed for the better between sessions; Trepper et al., 2014).

The core elements are co-constructed through the sessions by presuppositional language, i.e., the therapist assumes their existence (de Shazer, 1985, 1988). The co-construction is successful when the client answers the presuppositions by providing information on the given element. To meet their role in the co-construction clients need to be ready to answer SF questions. Thus, timing is relevant.

To aid practitioners in tailoring their intervention, several types of relationships were described based on the client's engagement with recommendations of what elements to emphasize.

Level of Engagement in SFBT

At the BFTC three types of therapist-client relationships were observed based on the client's attitude towards the problem (de Shazer, 1988): (1) *Visitor* – when clients have no complaint but attend therapy at the others' request; (2) *Complainant* – when clients recognize the existence of a problem but expect others to solve it due to not seeing their role in making a change or, if they do, they are blocked from taking any action; and (3) *Customer* – when clients show readiness to do something to solve their problem, are ready to move from talking to doing.

Despite not being defined in correspondence to readiness to change (de Shazer, 1988), Barbara McFarland (1995) made a parallel with the *stages* described in the Transtheoretical Model (Prochaska et al., 2008; Prochaska & DiClemente, 1982), assimilating Visitor to precontemplation (when clients do not intend to make the necessary steps to change), Complainant to contemplation (when clients think about the need to make a change but are not ready to commit), and Customer to preparation (when concrete action plans are formed) or action (when the plan is implemented in real life) stages – depending if the client can identify action tasks.

This distinction was also emphasized in the Bruges model developed at the Korzybski Institute, where the therapist-client relationship was defined based on the level of engagement. A fourth type was proposed, i.e., the *Consulting* one, comprising clients who are ready to take action but do not know how to due to not being aware of their resources and strengths (Isebaert, 2016). Additionally, the labels proposed by the BFTC were changed to reflect the relationship and not the individual. Yet, the proposed categories are not identical. The *Uncommitted* level comprises not only involuntary clients but also voluntary ones who do not specifically ask for help. *Searching* refers to clients who ask for help but are

not ready to act not only because they expect change from others but also due to having an unclear aim. At the Expert level clients are aware of their resources and the steps to be taken (Isebaert, 2016).

The BFTC and Bruges models are currently the only two distinct descriptions of the client's level of engagement in use in SFBT. Both models agree that the intervention should be different for each level. At the Visitor or Uncommitted level, identifying a working aim is difficult, thus the therapist should look for strengths and resources, give compliments, and increase the client's awareness of the situation by exploring disaster scenarios (de Shazer, 1988; Isebaert, 2016; McFarland, 1995). At the Complainant or Searching level, the miracle question, scaling questions, and search for pre-session change and exceptions can be used to help clients see their role in solving the problem and increase hope and motivation (Isebaert, 2016; McFarland, 1995). At the Customer or Consulting level, a workable aim can be defined alongside the search and reinforcement of strengths and solutions to increase client awareness (Isebaert, 2016; McFarland, 1995). Finally, at the Expert level, reinforcement of the client's strengths and abilities used to reach the aim is sufficient (Isebaert, 2016).

As evidence of the relationship between the intervention and level of engagement Phillip Ziegler (2010) added to the BFTC model labels describing the therapist's corresponding role: Visitor/Host, Complainant/Sympathizer, and Customer/Consultant. By overlooking the client's engagement, the therapist risks co-constructing elements for which the client is not ready.

Previous Studies on What Clients Find Helpful in SFBT

Overall little research was concerned with the client's view of the psychotherapeutic process (Hodgetts & Wright, 2007). Results indicated that clients perceive as helpful SF-specific elements, such as problem-free talk, hopes for the future, analyzing progress, and central philosophy (Northcott et al., 2021; Quick & Gizzo, 2007). They also appreciated the same generic aspects as clients attending other approaches (Elliott & Williams, 2003; Hodgetts & Wright, 2007; Timulak, 2007), such as the therapeutic relationship, the therapist's characteristics, and the possibility to talk about their life or feelings while being understood (Metcalf & Thomas, 1994; Northcott et al., 2021; Shilts et al., 1997). Yet, not all clients appreciated the same elements. For example, talking about feelings was perceived as helpful only by those patients with aphasia who experienced emotional distress (Northcott et al., 2021).

Variability in the perceived helpfulness of specific SF questions was observed, which also reflected in answering. Clients more easily answered to scaling than miracle questions (McKeel, 2012). The former was perceived as a helpful element to see progress and that their situation is not that bad, while the latter made them feel uncomfortable, despite giving them hope and clarifying the aim. Similarly, clients were more likely to identify changes between sessions, than before the start of therapy, yet the percentage of clients able to give answers varied across studies from 30% to 62.2% for the latter (Allgood et al., 1995; Johnson et al., 1998; Lawson, 1994), respectively from 56% to 80% for the former (Herrero de Vega & Beyebach, 2004; Reuterlov et al., 2000).

Thus, a question arises concerning what generates these differences. What makes a specific element or question helpful for one client and not for the other? While various explanations were put forward concerning the particular words used by the therapist (Allgood et al., 1995; Herrero de Vega & Beyebach, 2004; Johnson et al., 1998), the timing of asking the question in line with the client's level of engagement was seldom taken into account. The few available studies showed that at the Complainant level clients are not ready to define therapeutic goals, more effective being the investigation of pre-session change (Beyebach, 2014; Beyebach et al., 1996). Moreover, clients with no clear therapeutic aim appreciated more the possibility to talk things out; if the therapist was not in line with the clients' needs dissatisfaction was expressed (Northcott et al., 2021).

Objective

The current study aimed to answer two questions:

1. How much does the original SFBT model replicate in the feedback given by non-USA clients, and which elements are more frequently mentioned, in line with the existence of a core?

2. How does the perceived helpfulness of specific elements vary with the client's level of engagement? Both the BFTC and Bruges models were examined separately to provide useful insight for SF practitioners and trainers regardless of their preferred model.

By examining the empirical evidence, the current study can strengthen the observations made by practitioners and theoreticians (de Shazer, 1988; Isebaert, 2016; Lipchik, 2011; McFarland, 1995) and add to the existing guidelines for adjusting the intervention to the client's level of engagement. Overlooking clients' needs can lead to a longer rather than briefer process or even dropouts (Beyebach, 2014; Lipchik, 2011). Thus, despite being a brief intervention, the general recommendation in SFBT is to go slow (Fiske, 2008; Lipchik, 2011) and lead from behind (De Jong & Berg, 2012). Knowing what elements are helpful for what client can help practitioners better tailor the intervention by respecting the client's pace in the co-construction process.

Methods

Participants and Procedure

The study was conducted in a naturalistic setting. Data were collected from adult clients attending individual SF psychotherapy in private practice.

Initially, three psychotherapists with similar training in SFBT participated in the data collection. Later on, two of them withdrew to focus on other personal or professional projects, which left the third psychotherapist, i.e., the author, to continue the data collection. Considering the mixed-method design, to reach the theoretical saturation of responses (Giacomini et al., 2000) and ensure sufficient power for statistical analyses, data were collected over a period of two years, from 2019 to 2021.

A total of 317 clients were recruited by the author from the Lesser Poland province, with a lower proportion of answers obtained from a male (N = 17) and female (N = 12) therapist from Lodz, respectively Silesian provinces in Poland. The majority was females and paying clients, whose age ranged between 18 and 67 (see Table 1). Twenty-seven clients did not provide their ages. The number of visits attended ranged between 1 and 29, the median was 2 (1, 4). Some clients attending more than one session gave more than one answer at different moments.

Intervention

All three psychotherapists use SFBT in their private practice as their main approach in line with the SFBT treatment manual (Trepper et al., 2014) and the requirements defined by the European Brief Therapy Association Research Task Group (Beyebach, 2000). At the moment of data collection, their practical experience ranged from three to five years. All were attending the third of the four-year psychotherapeutic training representing level three of three in SFBT in Poland. The training was conducted by the Center for Brief Therapy in Lodz in collaboration with experienced therapists and supervisors of the European Brief Therapy Association. The program was in line with the national requirements to obtain certified qualification as a psychotherapist. During the four-year training, participants accumulate about 370 hours of training and supervision in SFBT, in addition to 900 hours in psychotherapy methods, clinical practice, and own psychotherapy.

Ethical Considerations

At the beginning of therapy, clients were informed of the possibility to use in research the information concerning the process aiming at its improvement. No incentives were given. Clients had no objections. Participants could object to data collection throughout the entire duration of the therapy. No identification data were collected. Initially, the ethical review was waived for this study due to its specificity, i.e., non-experimental, non-invasive, and with no effect on the subjects. Later on, the study protocol was submitted for evaluation and received a positive opinion from the Ethical Committee of the Polish Association for Solution-Focused Psychotherapy (no. 2/ 04.11.2022).

Data Collection

Both qualitative and quantitative data were collected simultaneously according to the concurrent mixed-method design. The qualitative data were collected by asking clients a standard question at the end of the session: "What from what happened here today was most helpful for you?". The therapists asked the question randomly, not to all clients, and regardless of the complaint, the number of sessions, type of therapeutic relationship, or level of satisfaction observed. The question was asked as a part of the therapeutic process. Clients attending SFBT are often asked to evaluate the helpfulness of the intervention so that they can use their expert point of view in guiding the treatment (Fiske, 2008; Metcalf & Thomas, 1994).

The quantitative data represented by the level of engagement was identified by the therapist leading the session. All therapists were trained to identify the therapist-client relationship defined in the BFTC model (de Shazer, 1988) at the Center for Brief Therapy in Lodz. For the Bruges model, each therapist used the Bruges flowchart completed with the description of each level of engagement (Isebaert, 2016).

Data Analysis

A three-stage data-transformation design was used. In the first stage, a thematic analysis was performed on the qualitative data to identify what elements of the SFBT process clients perceived as helpful. Thematic analysis was chosen as an adequate method to identify an individual's beliefs and experiences. Raw data were coded manually in the Excel spreadsheet. A coding framework was developed and continuously adapted to capture all answers. Codes, categories, and themes were inductively built, following current guidelines (Guest et al., 2012; Nowell et al., 2017). Codes and categories were labeled using participants' language. The themes were only finally named in line with current terminology to show a relation while not influencing the coding process.

In the second stage, the themes were quantified to identify which elements of the SFBT process were more frequently identified as helpful. Lastly, at the mixed method stage, odds ratios were computed to identify in what way the themes were connected to the quantitative data represented by the type of relationship. Fisher's exact test for count data was used to test the significance level when the distribution of themes by type of relationship was too low. All statistical analyses were performed in the R and R Studio program (R Core Team, 2021; RStudio Team, 2022). The "tidyverse" (Wickham et al., 2019), "psych" (Revelle, 2022), and "stats" (R Core Team, 2021) packages were used.

Data Trustworthiness

The trustworthiness of the qualitative analysis was ensured as follows. For credibility three persons were involved in data collection. When two withdrew, the data collected from the remaining therapist was prolonged for two years to avoid moderator bias. Also, to avoid the influence of therapists' knowledge of the SFBT process over the client's answers, no in-depth investigation was used to extrapolate more meaning. In this regard, the audio recording was not considered due to the short answers given by the clients, which allowed a direct transcription. Furthermore, coding and categories were based on the client's language. The prolonged engagement was used to obtain information at different moments of the process, by asking the same question at the end of various sessions to long-term clients.

The similarities observed in the client's responses collected by the author vs the two other therapists indicated replicability of the data in various settings, i.e., when sessions are performed by different practitioners. The objectivity of the data analysis was ensured by extending Guest et al.'s (2012) recommendation for when a second coder is not available through coding the entire data three instead of two times at a distance of two months between coding. Few inconsistencies were observed, with each coding leading to more precise labeling and categorization of participants' answers.

The author of this study is a licensed psychologist, with a doctoral degree in social sciences in the discipline of psychology, having seven years of experience in using the SF approach in the therapeutic setting. Since 2020 is a certified psychotherapist in accordance with the requirements of the Polish Psychotherapy Council. The author adheres to the SF philosophy and acknowledges the client to be the expert of their own experience, and thus considers that her views did not significantly influence the analysis or the results.

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Results

Descriptive Statistics

The descriptive statistics by level of engagement are presented in Table 1.

Table 1

Descriptive Statistics by Level of Engagement

		N	BFTC Model			Bruges model			
			Visitor	Complainant	Customer	Uncommitted	Searching	Consulting	Expert
Total		346	38	198	110	66	177	95	8
Gender									
	Female	256	26	151	79	51	131	69	5
	Male	90	12	47	31	15	46	26	3
Age									
	Mean	32.14	34.18	31.84	31.98	32.60	32.11	32.02	30.63
	SD	8.68	9.03	8.82	8.31	9.60	8.59	8.64	2.26
Type of therapy									
	Payed	301	36	172	93	62	152	79	8
	Free	45	2	26	17	4	25	16	0
No of sessions									
	1	167	20	120	27	38	104	25	0
	2-4	116	13	56	47	21	52	41	2
	>5	63	5	22	36	7	21	29	6

Note. BFTC – Brief Family Therapy Center.
 * *p* < .05; ** *p* < .01; *** *p* < .001.

No significant difference was found in clients' age by level of engagement neither as defined in the BFTC or Bruges models, Fs$(317,1)$ = .79 and .29, ps = .375 and .588. Similarly, no significant difference was found in the distribution of the levels of engagement by gender or free vs. payed treatment neither when considering the BFTC, χ^2s(2) = 1.41 and 2.60, ps = .493 and .293, or Bruges, χ^2s(3) = 1.01 and 5.44, ps = .760 and .154, models. Yet, significant differences were found by number of sessions in both BFTC, $\chi^2(4)$ = 42.37, p < .001 and Bruges, $\chi^2(6)$ = 50.43, p <.001, models.

Customer rather than Visitor, ORs = 2.68 [1.52; 6.23] and 5.33 [1.78; 16.02], zs = 2.29 and 2.98, ps =.022 and .003, or Complainant, ORs = 3.73 [2.11; 6.59] and 7.27 [3.70; 14.28], zs = 4.53 and 5.76, ps <. 001, was significantly more likely to be identified when the assessment was made in the second to fourth or fifth and further session compared to the first one. No significant difference was found in the distribution of Complainant vs. Visitor by number of sessions. Similarly, Expert rather than Searching was significantly more likely found in the fifth or further session compared to both first and second to forth ones, ORs = 63.19 [3.43; 1164.19] and 7.43 [1.39; 39.80], zs = 2.79 and 2.34, ps = .005 and .019. Also, Expert rather than Uncommitted was significantly more likely identified in the fifth or further session compared to the first one, ORs = 66.73 [3.39; 1315.11]. Additionally, Consulting was significantly more likely identified than Uncommitted or Searching, ORs = 6.30 [2.39; 16.57] and 5.78 [2.82; 11.70], zs = 3.73 and 4.82, all ps < .001, in the fifth or further than first session. No significant difference in the distribution of neither Expert vs. Consultant, nor Uncommitted vs. Searching levels by number of sessions was found.

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Thus, a similar tendency to identify clients with a higher level of engagement the more sessions they attend was observed when using both models. Yet it cannot be said in what way the movement from one level to another occurred, as it was not monitored longitudinally, this being beyond the scope of this research.

Thematic Analysis

Eleven main themes emerged additional to the one containing categories with a low frequency that did not fit in other themes. The frequencies per each theme, category, and subcategory are presented in Table 2 ordered chronologically by their use during the session and not traditionally based on their frequency. Nine themes were related to aspects specific to the SFBT process as previously described by other authors (de Shazer & Berg, 1997; Gingerich & Eisengart, 2000; Trepper et al., 2014). Themes 10 and 11 contained elements common to other therapeutic approaches, not previously mentioned in literature as SF core or characteristic elements, and thus I labeled them "generic". The themes with example quotes highlighted in italics are described below starting with the ones specific to the SFBT process.

Theme 1: Aim

Among the SFBT-specific themes, the highest frequency was reached by Aim comprising clients' answers related to the co-construction of the therapy goal. Within this theme, three categories and six subcategories were identified. Clients perceived as helpful (a) the definition of the aim by *having a clear formulation* of what they want, (b) the *realization of what they need* to achieve it, and (c) the analysis of the differences between the various *options* they have of living their life. The helpfulness of visualizing their preferred future was not always associated with the miracle question. Participants also appreciated their attitude toward change as they realized they could actively influence it, that change is *not that difficult,* and they *could do it.*

> "*All the questions you gave me regarding the concrete change in my behavior were helpful; to know how is it going to look like. Thanks to your questions now it is clear to me what I want and it doesn't look that difficult*" (female client, age not reported).

Theme 2: Exceptions

The theme comprising aspects related to the co-construction of exceptions had a lower relevancy, probably because clients may see past events not as a source for solutions, but rather for the problem. Three categories were identified: (a) *focusing on what works in their life* despite the problem, (b) analyzing the exceptions by looking into *the differences between situations in which they managed or not to cope* to identify *how* they did that, and (c) reaching the *awareness that their situation is not that bad*. The latter was often mentioned with the scaling questions (e.g., "*I realized I am not at zero!*"), in line with the purpose for which they were built (de Shazer & Berg, 1997).

> "*It was helpful to see the time perspective, to see how I was previously able to function despite having the same problem*" (female client, 27 years old).

Theme 3: Progress

This theme contained clients' answers related to the co-construction of progress toward the aim. Clients appreciated the talk about *what changed for the better* from one session to another. They perceived three aspects related to progress as helpful: (a) being able to see *improvements, how much they've managed to change* already, (2) *seeing that things are going in the right direction*, and (3) *realizing* that they've already reached their aim by being able to do those things which they were *only dreaming at the beginning of therapy*. These aspects were sometimes associated with scaling questions.

> "*It was helpful to make the list, to summarize all the positive things which happened since the last session, to see what went well and how*" (male client, 32 years old).

Table 2

What Clients Perceived as Helpful from the Therapeutic Process (N = 346)

Themes and categories (subcategories)	Frequency, n(%)
SFBT-specific themes	
Theme 1: Aim	**54 (15.61%)**
Defining what they want	27 (7.80%)
- clear definition of the aim	17 (4.91%)
- knowing what they need	7 (2.02%)
- analyzing differences in options	4 (1.16%)
Future-talk	18 (5.20%)
Attitude towards change	13 (3.76%)
- starts with them	7 (2.02%)
- easy	5 (1.45%)
- realistic	2 (0.58%)
Theme 2: Exceptions	**21 (6.07%)**
Focus on what already works	9 (2.60%)
Analyzing exceptions (the how)	7 (2.02%)
Awareness is not that bad	6 (1.73%)
Theme 3: Progress	**38 (10.98%)**
Seeing change	25 (7.23%)
Going in the right direction	11 (3.18%)
Reaching the aim	4 (1.16%)
Theme 4: Empowerment	**34 (9.83%)**
Awareness of personal strength	15(4.35%)
Confirmation of doing the right thing	11 (3.18%)
Complements	11 (3.18%)
Theme 5: Action	**49 (14.17%)**
Knowing what to do next	26 (7.51%)
Having a plan	12 (3.47%)
Having a direction	6 (1.73%)
Setting small steps	9 (2.60%)
- importance of small steps	5 (1.45%)
- setting first/next step	4 (1.16%)
Theme 6: Central philosophy	**37 (10.69%)**
Change what doesn't work	24 (6.94%)
- do something different	12 (3.47%)
- awareness of what is not helpful	8 (2.31%)
- differentiation between what is and is not helpful	4 (1.16%)
Do more of what works	9 (2.60%)
- repeat what already works	6 (1.73%)
- generalize what works	3 (0.87%)
If it isn't broken, don't fix it	4 (1.16%)
Theme 7: Hope and readiness to change	**29 (8.38%)**
Feeling hopeful	22 (6.36%)
Feeling motivated to act	9 (2.60%)
Theme 8: End-of-session feedback	**30 (8.67%)**
Suggestions	26 (7.51%)
Summarization	5 (1.45%)

Theme 9: Therapist's SF attitude	**18 (5.20%)**
Being listened to and understood	7 (2.02%)
Non judgmental	3 (0.87%)
Not giving advice	2 (0.58%)
Directedness	2 (0.58%)
Curiosity	2 (0.58%)
Positivity	2 (0.58%)
Faith in the client	1 (0.29%)
Not analyzing the past	1 (0.29%)
Generic themes	
Theme 10: Talking things out	**87 (25.14%)**
Talking it out	82 (23.70%)
Feeling better	10 (2.89%)
Theme 11: Awareness and understanding	**83 (23.99%)**
About self	31 (8.96%)
- understanding oneself better	15 (4.34%)
- being normal	5 (1.45%)
- not being at fault	3 (0.87%)
- awareness of personal rights	2 (0.58%)
- realizing own limited influence	6 (1.73%)
About the situation	30 (8.67%)
- having a better understanding	18 (5.20%)
- having a different perspective	12 (3.47%)
Reflecting	23 (6.65%)
- by receiving questions	20 (5.78%)
- putting thoughts in order	3 (0.87%)
Theme 12: Other aspects	**6 (1.73%)**
Starting the therapy	2 (0.58%)
Don't know yet	2 (0.58%)
Nothing	2 (0.58%)

Note. The total frequency of one theme is not equal to the identified categories, as one person may have mentioned several categories of the same theme, and thus was counted only once. Similarly, the total frequency of all themes is not equal to the number of participants, as one person may have mentioned several themes.

Theme 4: Empowerment

The answers on the helpfulness of the co-construction of empowerment-related aspects also clustered into three categories: (a) reaching awareness of already owned personal strength and *resources* such as *positive traits, being a strong person, or possessing tools,* (b*) reaching confirmation of already doing the right thing*, and (c) receiving compliments from the therapist. The latter category was included in the Empowerment theme for coherence despite complements being also a part of the end-of-session feedback (de Shazer & Berg, 1997). Empowerment and focus on strengths are relevant aspects of the SBT (Kim & Franklin, 2009; Trepper et al., 2014) present across the entire session.

> "*I realized I can cope because someone objective, not knowing me before, told me that I am doing something good. Do you know? - it does matter when you listen to compliments from somebody outside your family or friends*" (female client, 50 years old).

Theme 5: Action

The theme comprising aspects related to the co-construction of actions needed to reach the aim had the second highest frequency. It consisted of four categories: (a) *the concrete focus* on the "know-how" which helped clients *know*

what to do next, what is worth trying, (b) setting an *action plan*, (c) *having a direction of actions* to take, and (d) identifying what is the first or next step to take. Some clients realized that *they can't do it all at once,* and taking a *small step today is enough to make tomorrow different.*

> "*From today's session, I appreciated the focus on concrete aspects, the discussion about the way to achieve what I want, and those various steps of actions*" (male client, 27 years old).

Theme 6: Central Philosophy

A theme corresponding to the SF *Central philosophy* was also identified, as clients made referrals to all three elements described by de Shazer (1985). The most frequently mentioned element was connected to changing what doesn't work. Clients appreciated as helpful the understanding of what they were doing wrong or of *the differences between what is helpful and what is not.*

> "*The comparison between the problematic situations with that, what already works well at my workplace helped me understand. Now I realized what I was doing; what makes sense and what doesn't. I mean it makes no sense to fight against the situation*" (female client, 29 years old).

Other clients appreciated the *awareness* that they can *do something different.*
> "*I haven't thought before that I could react differently to what my partner does. Now I know that instead of arguing with him, I can just mind my own business and do what I want*" (female client, 25 years old).

Within the category corresponding to *repeating* what already works, two distinct subcategories were identified, i.e., doing more of what works for the particular problem *("I found out that I am doing the right thing, I am going in the good direction and I plan to keep on doing so."* male client, 24 years old), and generalizing what works from one life area into another *("I realized that if I am a master of planning, I can just use this in the relationship with my children",* female client, 34 years old).
The lowest frequency reached by the third central philosophy: "If it isn't broke, don't fix it", is not surprising considering that the majority of clients come to therapy for change.

> "*I realize now that the problem is not where I thought it was, that the situation is not that bad and that I do not have to change anything*" (female client, 45 years old).

Theme 7: Hope and Readiness to Change

This theme contains clients' answers reflecting *feeling* hopeful that the situation *is going to be better* and *motivated to act.* In line with previous research which found SF elements to be related to these aspects (McKeel, 2012). I considered this theme to be SFBT-specific.

> "*I can't wait to try this new idea out. I will create a stressful situation just to be able to try it*" (female client, 23 years old).

Theme 8: End-of-Session Feedback

This theme comprised clients' answers referring to the end-of-session feedback. The perceived helpfulness of the therapist's summarization and suggestions provides additional evidence for the relevancy of closing the sessions in this way. As mentioned previously, complements, despite being also a part of the end-of-session feedback, were accounted for as elements of empowerment.
> "*It was helpful the idea you gave me during the summarization to think about how it can be good and bad for me to take risks. I think this will help me get used to risk-taking*" (female client, 35 years old).

Theme 9: Therapist's SF Attitude

Few clients mentioned the therapist's attitude specific to the SFBT as being the most helpful part of the session, such as *the absence of evaluations*, *advice*, or *analyses of the past*. Some clients also appreciated the therapist's *curiosity* throughout the session, *positivity*, and *faith* in their ability to produce change. In turn, more clients appreciated *being heard and understood*.

> "*For me, it was helpful that you encouraged me to think without giving advice to 'do this or that', because this is a difficult situation in which I am in*" (female client, 37 years old).

Theme 10: Talking Things Out

The highest frequency was reached by the generic theme reflecting the client's possibility to *say out loud what they feel or think* and *share their thoughts with others*. Some clients justified the helpfulness of talking out loud as a consequence of having to *keep things for themselves, not to overload close ones*. The "talking it out" was the most frequently appreciated element of the session. Some clients also mentioned the immediate effect of relief by *feeling better*.

> "*I feel a bit better now because I was able to talk things out*" (female client, 35 years old).

Theme 11: Awareness and Understanding

The second highest frequency was reached by another generic theme reflecting clients' awareness and understanding of themselves or their situation. Clients appreciated *understanding themselves better* and *knowing why* they took particular actions. Also, it was helpful to *feel that they are normal* human beings and *not bad persons to blame*. A couple of clients appreciated the awareness of their human rights. Few found the awareness of their limited influence on the situation helpful, not to try to change things that can't be changed.

> "*Now I understand why in that particular situation I reacted as I did. I really want to understand my past*" (male client, 29 years old).

A similar amount of clients appreciated *understanding* the situation *better* and having *a different perspective*.

> "*I have a different perspective now. This meeting completely changed my thoughts about my daughter*" (female client, 49 years old).

Other clients appreciated the possibility to reflect upon their situation by *receiving* and *answering difficult questions* which otherwise they would not ask themselves. Also, it was helpful to *put their thoughts in order*.

> "*You give me difficult questions which irritate me, but also force me to think. I've never received such difficult questions, but they open my eyes to things I was not able to see before*" (female client, 20 years old).

The Importance of Themes Relative to Each Other

The two generic themes both had a significantly higher frequency than any other SFBT-specific theme, from the lowest (Therapist's SF attitude) to the highest (Aim) frequent ones; odds ratios ranged from 6.12 [3.59; 10.43] to 1.82 [1.24; 2.65], zs = 6.66 to 3.09, all ps <.002 for Talking things out, respectively from 5.75 [3.37; 9.82] to 1.71 [1.17; 2.50], zs = 6.41 to 2.75, all ps <.006 for Awareness and understanding theme. There was no significant difference between these two generic themes, OR = 1.05 [0.74; 1.48], z = 0.27, p = .791.

When analyzing frequencies, to see if a core can be identified among the SFBT-specific themes, results showed that Aim and Action were more likely, while Exceptions and Therapist's SF attitude were less likely to be mentioned by the clients. Namely, Aim was significantly more likely mentioned as a helpful theme compared to Exception, OR = 2.86

[1.69; 4.85], $z = 3.90$, $p < .001$, Empowerment, $OR = 1.70$ [1.07; 2.68], $z = 2.26$, $p = .024$, Hope and readiness to change, $OR = 2.02$ [1.25; 3.26], $z = 2.88$, $p = .004$, End-of-session feedback, $OR = 1.95$ [1.22; 3.13], $z = 2.76$, $p = .006$, and Therapist's SF attitude, $OR = 4.28$ [1.93; 5.88], $z = 4.28$, $p < .001$, respectively marginally more likely compared to Central philosophy, $OR = 1.54$ [0.99; 2.42], $z = 1.90$, $p = .057$ and Progress, $OR = 1.50$ [0.96; 2.34], $z = 1.78$, $p = .075$. Action was significantly more likely mentioned as a helpful theme compared to Exception, $OR = 2.55$ [1.50; 4.36], $z = 3.44$, $p < .001$, Hope and readiness to change, $OR = 1.80$ [1.11; 2.93], $z = 2.38$, $p = .017$, End-of-session feedback, $OR = 1.74$ [1.07; 2.81], $z = 2.25$, $p = .024$, and Therapist's SF attitude, $OR = 3.01$ [1.71; 5.28], $z = 3.84$, $p < .001$, respectively marginally more likely compared to Empowerment, $OR = 1.51$ [0.95; 2.41], $z = 1.75$, $p = .081$. Additionally, Exception was significantly less likely to be mentioned compared to Progress, $OR = 0.52$ [0.30; 0.91], $z = 2.28$, $p = .022$ and Central philosophy, $OR = 0.54$ [0.31; 0.94], $z = 2.17$, $p = .03$, and marginally less likely compared to Empowerment, $OR = 0.59$ [0.33; 1.04], $z = 1.81$, $p = .07$. Finally, Therapist's SF attitude was also significantly less likely mentioned compared to Progress, $OR = 0.44$ [0.25; 0.80], $z = 2.73$, $p = .006$, Empowerment, $OR = 0.50$ [0.28; 0.91], $z = 2.27$, $p = .02$, and Central philosophy, $OR = 0.46$ [0.26; 0.82], $z = 2.62$, $p = .009$.

Relation Between Themes and Level of Engagement

Significant differences in the distribution of themes by the client's level of engagement were found for Aim, Progress, Action, and Talking things out (see Table 3).

When considering the BFTC model Aim, Progress, and Action were significantly more likely reported in Customer than Complainant level, $ORs = 2.04$ [1.10; 3.75], 7.52 [3.41; 16.60], and 2.48 [1.31; 4.68], $zs = 2.28$, 4.99, and 2.80, $ps = .023$, .0001, and .005. Progress and Action were more likely reported in Customer than Visitor, $ORs = 27.87$ [1.66; 468.25] and 3.43 [0.97; 12.10], $zs = 2.31$ and 1.92, $ps = .021$ and .055, though the latter difference reached marginal statistical significance. In turn, the Talking things out theme was more likely reported in Complainant than Customer level, $OR = 4.99$ [2.37; 10.53], $z = 4.23$, $p < .001$. No significant difference was found between Complainant and Visitor.

When considering the Bruges model, Aim, Progress, and Action themes were significantly more likely reported in Consulting than Uncommitted level, $ORs = 3.88$ [1.25; 11.99], 50.71 [3.03; 849.10], and 3.90 [1.40; 10.87], $zs = 2.35$, 2.73, and 2.60, $ps = .019$, .006, .009. Progress and Action were more likely reported in Consulting than Searching level, $ORs = 7.03$ [3.13; 15.78] and 2.66 [1.36; 5.18], $zs = 4.73$ and 2.86, $ps < .004$. In turn, the Talking things out theme was more likely reported in Uncommitted or Searching than Consulting, $ORs = 9.26$ [3.72; 23.05] and 5.09 [2.21; 11.74], $zs = 4.79$ and 3.82, $ps < .001$, respectively in Uncommitted than Searching level, $OR = 1.82$ [1.01; 3.27], $z = 2.00$, $p = .045$. No significant difference was found regarding the Expert level, probably due to the low amount of clients in this group.

Discussion

The current study explored what elements of the therapeutic process conducted in line with the SF approach were perceived as helpful by clients outside the USA culture and how their helpfulness varied with the client's level of engagement. A mixed-method design was used in a naturalistic setting.

With one exception, all corresponding characteristics and core elements of the SFBT process including central philosophy (de Shazer & Berg, 1997; Gingerich & Eisengart, 2000; Trepper et al., 2014) were identified through thematic analysis of Polish clients' answers. The omission of pre-session change is not surprising considering that not all clients can identify them (Allgood et al., 1995; Johnson et al., 1998; Lawson, 1994). The break was not mentioned directly, yet it is an integral part of the end-of-session feedback (de Shazer & Berg, 1997), which was in turn perceived as helpful. These results provide empirical evidence for the replicability of the SFBT model beyond the USA culture where it was built.

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Table 3

Frequency of Themes by Level of Engagement

	BFTC Model				Bruges model				
	Visitor	Complainant	Customer		Uncommitted	Searching	Consulting	Expert	
Aim	4	25	25	$\chi^2(2) = 6.31^*$	4	29	19	2	$\chi^2(3) = 6.58^*$
Exception	1	15	5	$\chi^2(2) = 2.02$	3	13	5	0	$\chi^2(3) = 1.40$
Progress	0	9	29	$\chi^2(2) = 39.70^{***}$	0	9	26	3	$\chi^2(3) = 46.26^{***}$
Empowerment	5	14	15	$\chi^2(2) = 3.97$	6	16	10	2	$\chi^2(3) = 2.30$
Action	3	21	25	$\chi^2(2) = 9.93^{**}$	5	19	23	2	$\chi^2(3) = 12.73^{**}$
Central philosophy	4	24	9	$\chi^2(2) = 1.15$	7	21	8	1	$\chi^2(3) = .80$
Hope and readiness to change	2	17	10	$\chi^2(2) = .56$	4	16	8	1	$\chi^2(3) = .74$
End-of-session feedback	2	16	10	$\chi^2(2) = .63$	4	16	10	0	$\chi^2(3) = 1.77$
Therapist's attitude	4	11	3	$\chi^2(2) = 3.60$	5	10	3	0	$\chi^2(2) = 2.07$
Talking things out	17	61	9	$\chi^2(2) = 27.94^{***}$	28	51	7	1	$\chi^2(3) = 28.36^{***}$
Awareness and understanding	9	48	26	$\chi^2(2) = .02$	18	48	24	1	$\chi^2(3) = 1.06$
Other aspects	0	6	0	$\chi^2(2) = 4.56$	2	4	0	0	$\chi^2(3) = 2.76$

Note. BFTC – Brief Family Therapy Centre.
$^*p < .05; ^{**}p < .01; ^{***}p < .001.$

Additionally, clients perceived as helpful the same generic aspects identified in other therapeutic approaches by previous qualitative studies, i.e., the therapeutic relationship and awareness and insight following the possibility to talk about their feelings and experiences (Timulak, 2007). This similarity brings additional evidence against the critical voices which argue for the superficiality of the SFBT (Neves, 2017; Stalker et al., 1999). These generic elements were more frequently perceived as helpful than the SFBT-specific ones.

Based on these findings I propose a new organization of the SFBT model which accounts for the therapist's SF attitude and clients' possibility to talk things out and reach awareness and understanding as an essential environment for the co-construction process (see Figure 1). Additionally, I propose that the SF questions stand at a lower level serving as tools for the co-construction of specific aspects. This contrasts with existing proposals which include questions and their purpose at a similar level (Gingerich & Eisengart, 2000; Kim & Franklin, 2009; Trepper et al., 2014) or focus only on particular techniques (de Shazer & Berg, 1997). The currently proposed model emphasizes the co-construction process which is the essence of SFBT (de Shazer, 1985, 1988; Lipchik, 2011). It also moves beyond techniques by taking into account the relational aspect generic to all psychotherapeutic approaches.

Practical Implications

Current findings suggest that from the client's perspective the co-construction of Aim and Action is the most helpful SF-specific aspect. Yet, their perceived helpfulness did not vary significantly from the co-construction of Progress or Central philosophy probably due to their interconnection. In order to know what actions to take in reaching the aim, one must first be aware of the steps that led to progress to know what is worth repeating or changing (Central philosophy). Thus, if a minimum number of elements are to be considered (de Shazer & Berg, 1997; Gingerich & Eisengart, 2000), the emphasis should be on the co-construction of the aim, action, progress, and central philosophy.

Yet, if it is meant to be helpful, the co-construction process should consider the client's level of engagement. Current findings showed that the co-construction of the aim, action, and progress is more helpful for clients at a higher level, such as Customers (BFTC model) or Consulting (Bruges model). In turn, emphasis on the environment in which the co-construction takes place particularly by allowing the client to talk things out is more helpful at lower levels, such as Visitor or Complainant (BFTC model), respectively Uncommitted or Searching (Bruges model). These results bring empirical support to previous claims according to which at lower levels of engagement it is difficult to identify a working goal (de Shazer, 1988; Isebaert, 2016).
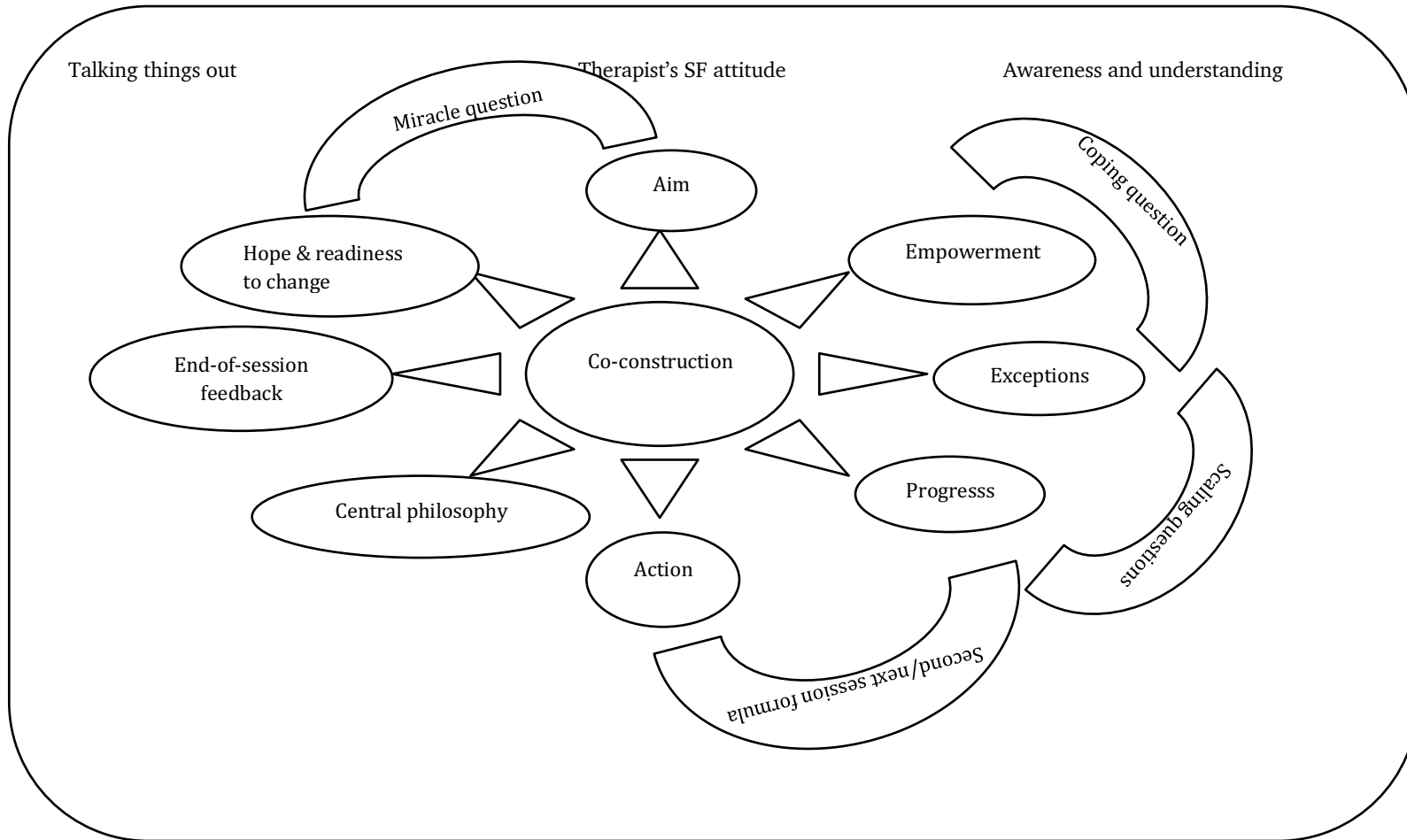
The relative relevance of various aspects of the therapeutic process identified in line with the level of engagement suggests that practitioners should move away from the automatic application of the model by paying attention to what the client standing in front of them is engaged in. These findings can help new SF practitioners avoid "problem-phobia" by allowing clients at lower levels of engagement to talk things out, so they can move towards higher levels and be ready to talk about goals and actions.

Limitations and Further Directions

The present findings and suggestions should be interpreted given the study's limitations. First, all psychotherapists were during their professional training, not yet certified. Nevertheless, in the formation years, one may be keener to follow the SFBT protocol purely. Also, all had at least three years of experience in the SF approach. In Poland following the second year of specialized training psychotherapists are sufficiently qualified to work under contract with the National Healthcare System.

Second, data was mainly collected from a single psychotherapist – the author, being also the only coder and main researcher for all aspects of the study. This may hinder the generalization of the results by reflecting more the personal rather than the SFBT model way of working. Yet, a practitioner-researcher can provide valid research if he/she follows the methodological protocols (McCormack, 2009). As described in the data analysis section for increased trustworthiness of the qualitative analysis I've gone beyond the general recommendations (Guest et al., 2012). Furthermore, the findings were in line with previous studies indicating the results' transferability.

The SFBT Co-construction Process and Environment Grounded in the Client's Perception

Third, the relative relevancy of various therapeutic elements may be specific to the characteristics of the sample. Paying clients attending by their own will psychotherapy in private practice may be more prone to appreciate the aim-and-action-focused intervention.

Future studies can replicate the results in other cultures with other populations, to test whether the perceived helpfulness varies culturally. For more information, in-depth questions can be used. Higher reliability can be provided by the inclusion of more experienced psychotherapists. Generalizability can be increased by recruiting clients from other settings.

Conclusion

The current study provides empirical support for the need to tailor the SF intervention in line with the client's level of engagement (de Shazer, 1988; Isebaert, 2016; Lipchik, 2011; McFarland, 1995). The law of instrument "*If the only tool you have is a hammer, you tend to see every problem as a nail*" (Maslow, 1966) applies as well to the SF practice. Over-reliance on the co-construction of solutions risks losing contact with the real client. The present model grounded in the client's perception shows that the SF co-construction process can coexist with the generic therapeutic environment common to other approaches; it is not a matter of "either, or". As a client said "*Talking out loud helped me realize what I was doing wrong*". Once the awareness sets in, the possibility to think of what to do differently opens.

Emphasis on building a good environment in which clients can talk things out is more appropriate at lower levels of engagement, while the more a client moves to higher levels, the more SF-specific elements are helpful. This is in line with the previous recommendation of going slow and not forcing the solution (Lipchik, 2011; Nylund & Corsiglia, 1994), while also not being problem-phobic.

References

Allgood, S. M., Parham, K. B., Salts, C. J., & Smith, T. A. (1995). The association between pretreatment change and unplanned termination in family therapy. *American Journal of Family Therapy*, *23*(3), 195–202. https://doi.org/10.1080/01926189508251350

Beyebach, M. (2000). *European Brief Therapy Association outcome study: Research definition*. https://solutionsdoc.co.uk/ebta-manual-protocol/

Beyebach, M. (2014). Change factors in solution-focused brief therapy: A review of the Salamanca studies. *Journal of Systemic Therapies*, *33*(1), 62–77. https://doi.org/10.1521/jsyt.2014.33.1.62

Beyebach, M., Rodríguez-Morejón, A., Palenzuela, D. L., & Rodriguez-Arias, J. L. (1996). Research on the process of solution-focused therapy. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 299–335). Jossey-Bass.

De Jong, P., & Berg, I. K. (2012). *Interviewing for solutions*. Brooks/Cole, Cengage Learning.

de Shazer, S. (1985). *Keys to solution in brief therapy*. W.W. Norton.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. WW Norton & Co.

de Shazer, S. (1994). *Words were originally magic*. Norton.

de Shazer, S., & Berg, I. K. (1997). "What works?" Remarks on research aspects of solution-focused brief therapy. *Journal of Family Therapy*, *19*(2), 121–124. https://doi.org/10.1111/1467-6427.00043

Elliott, M., & Williams, D. (2003). The client experience of counselling and psychotherapy. *Counselling Psychology Review*, *18*(1), 34–38.

Fiske, H. (2008). *Hope in action. Solution-focused conversations about suicide*. Taylor & Francis Group.

Giacomini, M. K., Cook, D. J., & Evidence-Based Medicine Working Group. (2000). Users' guides to the medical

literature: XXIII. Qualitative research in health care A. Are the results of the study valid? *Journal of the American Medical Association*, *284*(3), 357–362.

Gingerich, W. J., & Eisengart, W. J. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process*, *39*(4), 477–498.

Gingerich, W. J., & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process*, *39*(4), 477–498. https://doi.org/10.1111/j.1545-5300.2000.39408.x

Guest, G. S., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Sage Publications Inc.

Herrero de Vega, M., & Beyebach, M. (2004). Between-session change in solution-focused therapy: A replication. *Journal of Systemic Therapies*, *23*(2).

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology and Psychotherapy*, *14*(3), 157–163. https://doi.org/10.1002/cpp.527

Isebaert, L. (2016). *Solution-focused cognitive and systemic therapy*. Routledge. https://doi.org/10.4324/9781315559414

Johnson, L. N., Nelson, T. S., & Allgood, S. M. (1998). Noticing pretreatment change and therapy outcome: An initial study. *American Journal of Family Therapy*, *26*(2), 159–168. https://doi.org/10.1080/01926189808251095

Kim, J. S., & Franklin, C. (2009). Solution-focused brief therapy in schools: A review of the outcome literature. *Children and Youth Services Review*, *31*(4), 464–470. https://doi.org/10.1016/j.childyouth.2008.10.002

Lawson, D. (1994). Identifying pretreatment change. *Journal of Counseling & Development*, *72*(3), 244–248. https://doi.org/10.1002/j.1556-6676.1994.tb00929.x

Lipchik, E. (2011). *Beyond technique in solution-focused therapy. Working with emotions and the therapeutic relationship*. Guilford Press (Original work published 2002).

Maslow, A. H. (1966). *The psychology of science: A reconnaissance.* Harper & Row.

McCormack, B. (2009). Practitioner research. In S. Hardy, A. Titchen, B. McCormack, & K. Manley (Eds.), *Revealing nursing expertise through practitioner inquiry*. Wiley-Blackwell.

McFarland, B. (1995). *Brief therapy and eating disorders. A practical guide to solution-focused work with clients*. Jossey-Bass.

McKeel, J. (2012). What works in solution-focused brief therapy: A review of change process research. In C. Franklin, T. Trepper, W. Gingerich, & E. McCollum (Eds.), *Solution-focused brief therapy: A handbook of evidence based practice* (pp. 130–143). Oxford University Press.

Metcalf, L., & Thomas, F. (1994). Client and therapist perceptions of solution focused brief therapy: A qualitative analysis. *Journal of Family Psychotherapy*, *5*(4), 49–66. https://doi.org/10.1300/j085V05N04_06

Neipp, M. C., & Beyebach, M. (2022). The global outcomes of solution-focused brief therapy: A revision. *The American Journal of Family Therapy*, 1–18. https://doi.org/10.1080/01926187.2022.2069175

Neves, C. (2017). Critique of solution-focused brief therapy. In A. Blum & S. J. Murray (Eds.), *The ethics of care. Moral knowledge¸ communication and the art of caregiving* (pp. 195–208). Routledge. https://doi.org/10.5840/wcp23201829722

Northcott, S., Simpson, A., Thomas, S., Barnard, R., Burns, K., Hirani, S. P., & Hilari, K. (2021). "Now I am myself": Exploring how people with poststroke aphasia experienced solution-focused brief therapy within the SOFIA trial.

Qualitative Health Research, *31*(11), 2041–2055. https://doi.org/10.1177/10497323211020290

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1–13. https://doi.org/10.1177/1609406917733847

Nylund, D., & Corsiglia, V. (1994). Becoming solution-focused forced in brief therapy: Remembering something important we already knew. *Journal of Systemic Therapies*, *13*(1), 5–12. https://doi.org/10.1521/jsyt.2019.38.2.81

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, *19*(3), 276–288. https://doi.org/10.1037/h0088437

Prochaska, J. O., Redding, C. A., & Evers, K. E. (2008). The transtheoretical model and stages of change. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health behavior: Theory, research, and practice* (4th ed., pp. 97–122). Jossey-Bass.

Quick, E. K., & Gizzo, D. P. (2007). The "Doing what works" group: A quantitative and qualitative analysis of solution-focused group therapy. *Journal of Family Psychotherapy*, *18*(3), 65–84. https://doi.org/10.1300/J085v18n03_05

R Core Team. (2021). *R: A language and environment for statistical computing. R Foundation for Statistical Computing*. Vienna, Austria. https://www.r-project.org/

Reuterlov, H., Lofgren, T., Nordstrom, K., Ternstrom, A., & Miller, S. D. (2000). What is better? A preliminary investigation of between-session change. *Journal of Systemic Therapies*, *19*(1), 111–115. https://doi.org/10.1521/jsyt.2000.19.1.111

Revelle, W. (2022). *psych: Procedures for personality and psychological research*. Northwestern University, Evanston, Illinois, USA. https://cran.r-project.org/package=psych

RStudio Team. (2022). *RStudio: Integrated development environment for R.* http://www.rstudio.com/

Shilts, L., Rambo, A., & Hernandez, L. (1997). Clients helping therapists find solutions to their therapy. *Contemporary Family Therapy*, *19*(1), 117–132. https://doi.org/10.1023/A:1026118602095

Stalker, C. A., Levene, J. E., & Coady, N. F. (1999). Solution-focused brief therapy - One model fits all? *Families in Society*, *80*(5), 466–477. https://doi.org/10.1606/1044-3894.1476

Stams, G. J., Dekovic, M., Buist, K., & de Vries, L. (2006). Effectiviteit van oplossingsgerichte korte therapie: Een meta-analyse. [Efficacy of solution-focused brief therapy: A meta-analysis]. *Tijdschrift Voor Gedragstherapie*, *39*, 81–94.

Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research*, *17*(3), 305–314. https://doi.org/10.1080/10503300600608116

Trepper, T. S., McCollum, E. E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2014). Solution-focused therapy treatment manual for working with individuals. In *Solution-Focused Brief Therapy: A Multicultural Approach* (pp. 14–31). SAGE Publications Inc. https://doi.org/10.4135/9781483352930.n2

Wickham, H., Averick, M., Bryan, J., Chang, W., McGowan, L., François, R., Grolemund, G., Hayes, A., Henry, L., Hester, J., Kuhn, M., Pedersen, T., Miller, E., Bache, S., Müller, K., Ooms, J., Robinson, D., Seidel, D., Spinu, V., … Yutani, H. (2019). Welcome to the tidyverse. *Journal of Open Source Software*, *4*(43), 1686.

https://doi.org/10.21105/joss.01686

Ziegler, P. B. (2010). "Visitor," "Complainant," "Customer" Revisited. In T. S. Nelson (Ed.), *Doing something different: Solution-focused brief therapy practices* (pp. 39–44). Taylor & Francis Group.

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