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Creating a Common Language: How Solution Focused Brief Therapy Reflects Current Principles of change and Common Factors

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Cover Page Footnote

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ARTICLE

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Introduction

The debate between advocates for a common factors and principles of change perspective versus proponents of a model-specific approach has been going on for quite some time (Sprenkle et al., 2009). In this paper we will provide a brief overview of the common factors/mechanism of change literature, a brief review of the solution-focused brief therapy (SFBT) approach, and we will articulate why valuing both perspectives may contribute an expanded evidence-base for SFBT. In addition, we will consider the benefits for SFBT clinicians to be able to converse with other clinicians and stakeholders in a common language about the effectiveness of SFBT and how SFBT utilizes similar mechanisms of change as other approaches. Finally, we will consider research and clinical implications of this broadened perspective.

Literature Review

Common Factors/Mechanisms of Change

The importance of identifying the factors that produce change in psychotherapy despite specific modalities and understanding how psychotherapy produces benefits has been a point of interest for many over an extended period of time. The subject of common factors in various methods of psychotherapy was first addressed by Rosenzweig (1936). He is quoted by McAleavey and Castonguay (2015) that "psychotherapies that are different do indeed have many similar features, and these similar features may be responsible in some way for the fact that proponents of many treatments report success" (pp. 2). McAleavey and Castonguay also state that "it is not in-controversial to say that psychotherapies of many origins share several features of process and content, and it follows that better understating the patterns of these commonalities may be an important part of better understanding the effects of psychotherapy" (pp. 2).

The idea of common factors and core principles of change has not been met with universal support. Some feel that this approach may dilute the importance of "specific or unique" factors for each school of psychotherapy (Mulder et al., 2017). For many reasons (both personal and political), there is pressure to demonstrate how one treatment modality is more effective than others. Although this may benefit the "the school" or "the theory", it does not help create a core consensus or understanding in our field. Nor does it help individuals within the field evaluate different approaches in a uniform way. This lack of consensus often leads to arguments and efforts to prove each other wrong, instead of attempts to understand and collaborate with one another for the benefit of all clients. Goldfried (2018) purports there is a disconnect between our past and our present in the field of psychotherapy. He states that psychotherapy "lacks a common core and always seems to be at the cutting edge, not building upon past contribution and instead emphasizing with what is new" (p. 3). This pressure to be on the cutting edge pushes clinicians to emphasize where they stand apart and where they are making a unique contribution to the field, rather than acknowledging what shoulders they stand on, or how they are building on the philosophies and under-standing from those who have come before. This approach is in stark contrast to much of science,

which attempts to build on the past while adopting new modalities which facilitates a mutual under-standing and agreement.

Currently, psychotherapy advocates that being on the cutting edge is valuable and important, but equally important is the need to understand what factors contribute to change for clients, some of which are consistent across treatment modalities. Identifying common change factors allows clinicians to work effectively with clients without needing to recreate the wheel each time. In addition, identifying unique or specific factors that work for each clinician or each approach may enhance the work for each individual clinician. Without studying the interaction of common fac-tors/mechanisms of change, unique therapist factors, and unique approach factors, we are at risk of not being useful to our clients. As Goldfried (2018) said, "having different theory based language systems prevents us from ever learning of any similarities and points of complementarity across orientations" (pp. 2). The absence of a common language keeps psychotherapy from coming to a consensus about what works and what does not within psychotherapy (Norcross & Thomas, 1998).

Although we come from a solution focused brief therapy (SFBT) background, we are working toward two goals with this article. The first goal by presenting this research analysis is that SFBT therapists will be able to express, in a shared language, what we do well. Hopefully, the shared description and language provided will make agreements more accessible between SFBT therapists and their colleagues who work from different approaches. Hopefully, SFBT practitioners will be more easily able to describe shared avenues of change versus differentiating strategies and theories, thus making it more feasible to meet the goals of organizations to do the "best" therapy.

Our second goal is to demonstrate how SFBT reflects these common factors and principles and how these principles broaden the evidence-base for SFBT as a therapeutic approach. We hope this broadened evidence-base will help make an impact both within individual sessions and generally within the profession.

Solution Focused Brief Therapy

Solution Focused Brief Therapy was originally developed by Steve de Shazer, Insoo Kim Berg and their colleagues (de Shazer et al., 2007). SFBT is founded on the simple practices of: (a) looking for resources rather than deficits, (b) exploring possible and preferred futures through detailed conversations, and (c) investigating what is already happening that contributes to these preferred futures (George et al., 2017). Typically, SFBT sessions begin by assessing the client's best hopes or desired outcome from the session and transition to eliciting a detailed description associated with the presence of this desired outcome. Time may be spent investigating with the client, through questions, resources the client has that would help bring this desired outcome to pass, instances where pieces of the preferred future are already occurring or highlighting progress that has already taken place (George et al.). SFBT sessions are language-based and co-construct with the client new realities through the use of changes in language (de Shazer et al.). We were interested in identifying how this language-focused approach works to create lasting change in ways that were similar to, and perhaps different than other therapeutic approaches.

Methods

As a first step to identifying SFBT's fit within the common factors/mechanisms of change literature, we reviewed the current common factors literature in order to determine which perspectives to include in this modified content analysis. Content analyses are used to identify common patterns of themes in written documents and to make inferences based on these patterns (Hsiu-Fang & Shannon, 2005). The articles included in this study were each:

1. Published/produced in the last 15 years (since 2005). This was to ensure relevance regarding most recent literature.
2. Published/produced by an author(s) who has/have written or contributed significantly to the common factors literature base.
3. Consistent with mainstream literature regarding common factors.

These criteria, although not significantly rigorous, served the purpose of having a well-founded literature base. Although many other articles may have met these criteria, it was determined that since the focus of this study was on applying the common factors literature to the solution focused approach, and not on evaluating the common factors validity, that face validity and content validity of the included studies were the most important factors. In addition, because the focus of this paper was on applying the themes to SFBT and not providing a comprehensive representation of all common factors

literature, that an exhaustive inclusion of all potential articles was not needed, but rather a representative sample would be sufficient.

Included Articles

For the purposes of this paper – to work towards the potential of creating a common language and to demonstrate how SFBT reflects these factors and principles--we have presented the research of the following papers:

1. *The Question of Expertise in Psychotherapy* (2008) by Scott Miller, Mark Hubble and Daryl Chow
2. *Obtaining Consensus in Psychotherapy: What Hold Us Back* (2008) by Marvin Goldfried
3. *General Change Mechanisms: The Relation Between Problem Activation and Resource Activation in Successful and Unsuccessful Therapeutic Interactions* (2006) by Daniel Gassman and Klaus Grawe
4. *How Important are the Common Factors in Psychotherapy? An Update* (2015) by Bruce Wampold

Below we provide a brief summary of each of the articles included in the analysis.

Miller, Hubble, and Chow

This article asserts that all treatment that applies current common factors will lead to good therapy. In their Common Factors Model there are four areas including: (a) therapeutic technique, (b) expectancy and placebo, (c) therapeutic relationships, and (d) client factors. The authors posited that therapeutic techniques account for 15% of change, expectancy and placebo 15%, the therapeutic relationship accounts for 30-50%, use of client factors is responsible for 40% of change. Their model is the only model (of the included articles within this study) that gives specific percentages – but the research on all models generally seems to substantiate these numbers. Thus, emphasis should be on all factors that support strong alliance with the client and the many ways of utilizing client factors.

Goldfried

Goldfried presents his research on principles and mechanisms of change. He promotes moving the field of psychotherapy from theoretical considerations to agree upon principles of change. The specific intervention and techniques may then be thought of as methods of implementing these principles. They can be summed up as "…clients change when they are motivated and have positive expectations of change, work with a therapist with whom they have a good alliance, become better aware of what is causing the problem, take steps to make changes, … and engage in ongoing reality testing …". (p 6). His core principle of change can be described as working to-wards "the client doing something not done before". It does not matter how or under what circumstances the change takes place or whether it is phenomenological or observable.

Gassman and Grawe

Gassman and Grawe focused on the processes underlying change. They emphasized the role and balance of problem activation versus resource activations across therapies to support therapeutic change. They concluded that therapists who viewed the client as capable and more than the "sum of their parts," and engaged the client very early on in the session with the healthy parts of the client's life and personality, created an environment that promoted more productive work with the client. They found that these clients left the session with "higher activated resources" than when they entered.

Wampold

The final model we included in this study was Wampold's Contextual Model. His overall observation was that all therapies with a structure provided by an empathetic and caring therapist, which facilitates client engagement in healthy behaviors will have equal effects. He presents three interacting but "reasonably independent" pathways. These three pathways echo all the current research on common factors and principles of change. These include *Pathway 1 – Real Relationship, Pathway 2 – Expectations, and Pathway 3- Specific Ingredients.* Wampold, as well as the other researchers reviewed in this paper emphasize two further points, 1) the importance of "robust therapists," that is, the therapists having ability to form strong alliances, possessing strong interpersonal skills and engaging in practice outside the therapy sessions, and 2) the importance of inviting ongoing feedback from the client with regular monitoring of progress and process either formally or informally.

Inter-rater Reliability

After the included articles/studies were identified, Beverley Kort (BK) and Cecil Walker (CW) each did an initial qualitative content analysis review of the articles to identify specific com-mon factors and principles of change identified within each of the articles. The reviewers began with open coding, then moved to axial coding while maintaining field notes regarding their decision making (Stauss & Corbin, 1998). Qualitative inter-rater reliability was evaluated and Adam Froerer (AF) served as an arbitrator through this reliability process. Seven themes were identified across the included studies (see Table 1 in the Results Section for more extensive definitions). These themes included: (a) Ideology/Rational, (b) Expectation/Hope and Resource Activation, (c) Therapeutic Alliance, (d) Tasks of Therapy, (e) Use of Client Factors, (f) Therapist Effects and Self Regulation, and (g) Monitoring and Process Outcome.

Once the Common Factor/Mechanisms of Change themes were identified, the researchers then did a second modified qualitative content analysis comparison applying the seven identified themes to the Briefer practice manual (George et al., 2017) to evaluate how SFBT fits within the common factors and principles of change identified during phase one of the content analysis. Again, BK and CW served as independent reviewers during this process and qualitative inter-rater reliability was checked again, with AF serving as arbitrator when needed (see Table 2 for results).

Results

Step One of the content analysis resulted in seven themes being identified. See Table 1 for a breakdown of the overall themes with how each article fit within the themes.

The results of the second qualitative content analysis looked at how SFBT fit within the themes identified in Step One. The results of this second analysis are included in Table 2. It is important to note that *Ideology and Rationale* was excluded from the Table 2 results because this is an overall principle and is not specifically noted within practice/treatment manuals.

Discussion and Conclusion

The seven factors identified in the qualitative content analysis fit nicely with SFBT and help SFBT to fit into the larger frame of psychotherapy. We will first discuss each of the seven themes and why they have been deemed necessary for effective psychotherapy. Then after each of the themes is discussed, we will discuss in an applications section the specific theme from a non-SFBT and a SFBT perspective to facilitate mutual understanding of how different practitioners can attend to the same important factors but do so in different ways.

Table 1

Common Factor and Mechanisms of Change Themes

Theme	Miller, Hubble & Chow	Goldfried	Gassman & Grawe	Wampold
Ideology/ Rationale	All treatment that is a reflection of current common factors will lead to good therapy. - Therapeutic technique - Expectancy and Placebo - Therapeutic relationship - Client factors	Move from theoretical considerations to Principles of change. Clients change when: - Motivated and have positive expectations of change - Work with a therapist with whom they have a good alliance - Awareness of what is causing problems - Take steps to make changes in thinking, feeling and behavior - Engage in ongoing reality testing	"Resource activation is an empirically strongly supported change mechanism… realized in interventions that focus not on the patient's problems, but rather on the sound and healthy parts of the patient's personality."	All therapies with a structure or given by an empathetic and caring therapist, which facilitates client engagement in healthy behaviors will have equal effects. All treatment achieve their effects through three interacting but reasonably independent Pathways Pathway 1 : Real Relationship Pathway 2: Expectations Pathway 3 : Specific Ingredients
Expectations / Hope	Expectancy and Placebo - Creating hope greatly influenced by therapist attitude toward patient in *early moments* of therapy	- Promote client expectations and motivation that therapy can help - Recognizing/ experiencing what positive change would be like	Successful therapists in study focused right at the beginning of the session markedly on what worked well with patient-Resource Activation	Pathway 2: Expectations - Client is provided with an adaptive context that allows for solutions - Client believes participating will be helpful - Agreement of goals and tasks increases the therapeutic alliance
Therapeutic Alliance	Therapeutic Relations - Experience change early on in therapy, increases therapeutic alliance - Positive client experience of therapeutic alliance. - Therapist creates an environment that matches client's definition of empathy, genuineness, respectfulness and worldview	Therapeutic Alliance Defined as: - Good bond - Agreement to the goals of therapy and methods used - Most important transtheoretical principle of change	Engaging in early Resource Activation created an environment where the patient was perceived as a well-functioning person	Pathway 1: Real Relationship - Occurs through social support, interpersonal connection and belongingness or attachment between client and therapist - Early symptom relief leads to therapeutic alliance and successful outcomes - Goal collaboration led to most successful outcomes

Tasks of Therapy	- Emphasis on client's goals vs history and psychopathology - Across all models therapists expect their clients to, 1) Do something different, 2) Develop new understandings, 3) Feel emotions, 4) Face fears, 5) Take risks, 6) Alter old patterns	- Agreement about goals of therapy and methods to achieve these goals - Facilitating client awareness of factors associated with their difficulties - Core principle of change is client does something not done before - Reality Testing	Clients leave a session with even higher activated resources that they experienced when they entered the session.	Pathway 3 - Specific Ingredients - Treatment that a client finds acceptable that will lead to healthy actions that will decrease their distress - Induce client to enact healthy actions regardless of treatment specifics
Use of Client Factors	- More client involvement leads to more possibility of change - Take into account strengths, resources, current situation, fortuitous events, world view, etc.	Recognize and make use of previous life experiences that may be helpful with current difficulties	View of client as capable and more than the sum of their problems	-Explanation/rationale must be acceptable to client - Explanations congruent to cultural and personal beliefs
Therapist Effect and Self Regulation	Engage in "deliberate practice" to improve skills and maintain best practices in the following: - Quality of the therapeutic relationship - Creation of hope and expectation of change - Provision of plausible rationale and healing rituals - Understanding and use of client strengths - Therapist self regulation	- Learn skills that reflect commonalities that exist across theoretical orientations - Get supervision from therapists that are still actively in practice	Respond quickly to activated resource - no lag time	Robust therapists: - Able to form a strong alliance across a range of clients - Have a greater level of facilitative interpersonal skills - Express more personal self doubt - Engage in practice outside therapy sessions
Monitoring and Process Outcome	Use Feedback Informed Therapy tools	- Monitoring process and outcome on a session by session basis - Utilize the feedback to inform your therapy		

Table 2

*SFBT Ideas for Implementation based on Briefer: A Solution Focused Practice Manual**

Expectation and Hope	***Therapeutic Alliance***	***Tasks of Therapy***	***Use of Client Factors***	***Therapist Effect/Self Regulation***	***Monitoring Progress and Outcome***
- Best Hopes - What do you want instead? - Future Focus - Direction established by client - Client takes credit for change - Nurture sense of possibility: "So far" "As yet" "In spite of" - Noticing - Instances/ exceptions - Noticing small signs of progress - Start each subsequent session with "What's better"?	- Resource talk and Best Hopes - Use of client language, description, world view - Collaboration on client's desired outcome - One foot in the present and one foot in possibilities - Checking in regularly to make sure going in the right direction - Safety scaling questions	- Questions as a provocation for client to think about, to notice, and name differences - Desired outcome drives the session - Preferred Future - Client given credit through scales - Questions that remove contingencies in the way - Instances and exceptions - Noticing changes - Coping questions - Constructive history questions - Identity questions	- Instances and exceptions - Pre-meeting change - "What's better" - Coping questions - Building on already existing skills - Identity questions - Lists - "What else questions" to expand present and past successes - "Scaling questions" to discover what client has already accomplished	- Asking "What does the client want from therapy?"- How does that influence the next questions? - Making room for client/ identity, background, beliefs and views - Letting go of assumptions - Staying neutral and marginal in the client's life	- First small signs of progress - Scaling - Checking in with client on direction of session during each session - Magnifying change - Exceptions and Instances of change

**George et al. (2017)*

Ideology/Rationale

Brown (2015) states that it is an ethical imperative for clinicians to base their services on "evidence-supported" practices (p. 307). He goes on to say that since most therapies appear to be effective according to reviews of psychotherapy regardless of technique, it is becoming more apparent that "highlighting treatment principles rather than treatment strategies as a way of discussing active ingredients of change" (p. 307) would yield better results.

In his implications for therapists he emphasizes the importance of focusing on common factors that highlight both process and content (for example, the client therapist relationship and client experience of change). He further emphasizes the importance of focusing on principles rather than strategies of change. This allows the therapist to be "drawn directly to a range of therapies that are evidence supported and provide principles that evoke thinking across therapies in dealing effectively with clients" (pp. 311-312).

In their review of current psychotherapy research and reports by therapists of diverse allegiance, Castonguay et al (2015) discovered that "many behaved in ways that were more similar than dissimilar" (pp. 4). Many of the 'unique' interventions of particular orientations are idiosyncratic manifestation of more general strategies or principles of change, such as increase of positive expectations, provision of a new view of self or testing of change with day to day reality (Goldfried, 1980; Goldfried & Padawer, 1982).

Applications

Non-SFBT. From other non-SFBT therapeutic approaches, it is important to spend at least 2-3 sessions doing psycho-social assessment and information gathering about history and problem in order to properly evaluate client concerns and arrive at a diagnosis. The treatment process follows the diagnosis, and the goal is to alleviate symptoms.

SFBT. From a SFBT perspective, through conversations with the client, SF practitioners co-construct the client's vision of their desired outcome to determine where they want to go rather than a description of where they have been or what problems they are experiencing. First sessions are often treated as "working sessions" as the assumption is that each session may be the last. Solution Focused practitioners hold the belief that clients are the experts of their lives and should contribute their content-expertise to the process-expertise of the clinician. Both SFBT and non-SFBT perspectives hold values about how to help and aid clients, but enact these beliefs in different ways.

Expectation/Hope

Hope and expectancy are commonly cited as responsible for a substantial percentage of the variance in the outcomes of therapy (Lambert, 1992). Hope is best described as "the sum of the mental willpower and way power that you have towards your goals" (Snyder, 1994, p. 5). It is well established that a model that can activate hope and positive expectations in clients tends to have more positive therapeutic outcomes. Potential reasoning for that positive relationship includes the tendency of hope to be accompanied by positive affect (Ciarrochi et al., 2015) which can have extensive influence on an individual's cognitive flexibility and access to mental resources (Estrada et al., 1994). The client's expectations play a direct role in stimulating positive change (Constantino & Westra, 2012).

Applications

Non-SFBT. A common way therapeutic models build and make use of hope is in the construction of goals, since defined objectives and forward thinking are central to developing hope (Cheavens et al.,2006). Non-SFBT models might also emphasize how the execution of their interventions will help clients progress towards goal attainment, such as completing homework or finding insight in genograms. These insight- and task-oriented explanations offer clients a consistent approach that meets their expectations about the process of overcoming problems, whether through faulty cognitions or relational triangulation, or other problem-focused conceptualizations. Hope is often fostered through developing insight and goals for overcoming challenges.

SFBT. Solution Focused Brief Therapy emphasizes the significance of increasing positive expectancy and hope (Reiter, 2010). SFBT begins work with clients by inquiring about each client's best hopes (George et al., 2017). Through detail-oriented questions, SFBT therapists build realities that are founded on the best hopes established right at the beginning of each session. SFBT therapists continue building hope by asking clients to detail times where the problem was not so significant (exceptions) or even better, times when pieces of the best hopes were previously present in the client's life (instances). SFBT therapists infuse hope into questions throughout sessions by using presuppositions that highlight the client's strengths, resources, or abilities (Bavelas et al, 2013). SFBT is effective at building hope because of the way it manifests to clients the ways their present reality might connect to a preferred future, an understanding of which is a key facet of hopefulness (Rand & Cheavens, 2009).

Therapeutic Alliance

Therapeutic or working alliance is the common factor that has received the most attention. Horvath et al. (2011) identified over 200 research reports on the working alliance (for individual therapy for adults) that supports its robustness in correlation with positive outcomes in therapy. The quality of the therapeutic relationship in general, and the alliance in particular, are obvious 'common factors' shared by most if not all psychotherapies (Horvath et al., 2011). Other relationship variables that cut across theoretical orientations and received empirical support include empathy and positive regard. Several of the other therapeutic factors are enhanced by or inversely contribute to the therapeutic alliance, giving it exponential influence in the outcomes of therapy.

Applications

Non-SFBT. Most therapy models seem to agree on the importance of the therapeutic alliance. From non-SFBT theoretical perspectives, the therapeutic alliance is established through intentionally fostering an empathetic bond, joining, and expressing empathy for problems encountered by clients. More specifically, some approaches even seek to construct an attachment bond between the client and the therapist or join the family system and learn the rules that govern it. Within these other modalities, these bonds are built through respect towards the client, validating their experiences, and the agreement on goals and therapy tasks.

SFBT. Although SFBT does not overtly include "alliance-building" as a part of the theoretical approach, a focus on developing a working relationship with clients is absolutely at the forefront of what SFBT clinicians do. This working relationship is built on language and happens through the co-constructive process. This building of conversations on the clients' perspective and understanding fosters significance and relevance for the client, which in turn translates to trust and a more positive view of therapy.

Tasks of Therapy

Within the therapeutic process, the tasks of therapy involve the "behaviors and processes within the therapy session that constitute the actual work of therapy. Both the therapist and client must view these tasks as important and appropriate for a strong therapeutic alliance to exist" (Asay & Lambert, 1999, p. 35). The tasks included in any model are strongly tied to the expectancy it can build in clients, the construction of goals, as well as the therapeutic alliance. Positive outcomes depend on the fostering of the client's trust that the "means" of therapy are guiding them in a productive and hopeful direction. The tasks of therapy are observable mechanisms within therapeutic interactions to which clients might attribute the action of progress.

Applications

Non-SFBT: Non-SFBT approaches can have a variety of tasks of therapy, all sharing the understanding that these tasks will move the therapy forward. Examples of this might include family sculpting (Expe-riential), cognitive reframing (CBT), or heightening emotions (Emotionally Focused Therapy). All of these tasks provide the client with action that might explain or induce their potential progress. Therapeutic tasks are the tools clinicians from any approach use to assist clients in the change process. The theoretical assumptions underlying the approach have direct influence over the specific tasks that are selected and utilized by various practitioners.

SFBT. The tasks within SFBT are exclusively based on language. These may include inquiring about best hopes, focusing on the preferred future, discussing resources, noticing exceptions and instances, and asking questions about coping and resilience, among other questions. While the interaction is very conversational and dependent on the clients' words and perspective, these conversations lead to observable actions and positive change.

Client Factors

Client factors are the most robust predictors of successful therapy. Bohart and Tallman (2010) assert that although specific techniques and approaches can influence therapy outcomes, it is the client's ability to operate upon their therapist's input that ultimately brings about a positive result. Clients use and tailor what each approach provides to address their specific problems. Bohart and Tallman continue by promoting, "instead of technical know-how, the therapist helps primarily by supporting, nurturing, or guiding and structures the client's self-change efforts" (pp. 95). Their suggestions include some of the following: promoting client strengths, resources and person-al agency, believing all clients are motivated, and privileging clients' experiences and ideas.

Applications

Non-SFBT. When looking at the client from the perspective of other approaches, a therapist might examine what the client has done to perpetuate their problem, or what maladaptive beliefs perpetuate problems. Similarly, therapists might assess the client's level of motivation, personality, and symptomatology to increase positive therapeutic outcomes. Many psychotherapy approaches may buy into the belief that, "things might get worse before they get better".

SFBT. In SFBT, the goal is also to increase positive therapeutic outcomes by engaging client factors, but the way the client factors are utilized looks a little different. SFBT will draw on client factors through language rather than behavior interventions or homework tasks, etc. SFBT utilizes the client's strengths and resources as well as evidence of past successes to be applied to the current situation. The assumption is that all clients who present for therapy want to change, so their level of motivation is not questioned, their personality is not assessed, nor are the symptoms of the problem seen as valuable as their desired outcome.

Therapist Effect

While effective therapy requires an organized ideology and relies heavily on the relationship established between client and therapist, there is still room for the influence of the clinician's therapeutic skill. The clients of effective psychotherapists improve at a rate 50% higher and drop out 50% lower than less effective therapists (Skovholt & Jennings, 2004). Similar to how general therapeutic principles are more influential than the specific approach being used, the clinician and his/her clinical skills are also more important than the specific treatment being implemented in contributing to patient outcomes (Sperry & Carlson, 2013). Likely because of its relation to the therapeutic alliance, who the person is as the clinician can make a difference in therapeutic outcomes (Horvath et al., 2011).

Applications

Non-SFBT. In other therapeutic strategies, there is a focus on the clinical ability to execute the particular approach and concentrate on developing interventions and/or psychoeducation suggestions as a framework following diagnostic principles. The therapist must be skilled in understanding clinical diagnoses as well as the appropriate clinical responses to them. In many approaches there are predetermined directions for the therapeutic process that clinicians must be capable of accurately following. In many approaches the therapist is seen as the expert and holds a significant responsibility for creating change on behalf of clients.

SFBT. In SFBT, there is more of a focus on how well the therapist listens and sticks to the client's use of language to develop a rich description of their preferred future. It is important to make room for the client's background and the client's views and let go of any assumptions about the direction or outcome the client wants from therapy. A skilled SFBT therapist is able to stay neutral about the clients' life or choices. The therapist should be very skilled at asking detailed questions and helping the client co-construct a detailed description of the client's preferred future, while leaving their own options and expectations outside of the developed description.

Monitoring Process and Outcome

It is easy for the therapist to develop an inaccurate view of the client's treatment process (Walfish et al., 2012). The client's own subjective experience of change early in the treatment process, however, is a good predictor of treatment success (Norcross, 2002). The client's evaluation of the quality of the psychotherapeutic relationship is a better predictor of the therapeutic alliance and treatment outcome than is the psychotherapist's evaluation of the therapeutic alliance (Horvath et al., 2011). Several of the factors identified in this paper as well as positive outcomes in general all seem to rely heavily on the client's regard of the therapy process. This all supports why means of monitoring the process and measuring outcomes is beneficial to the efficacy of the therapeutic approach in providing the client and therapist with shared tools for observing change.

Applications

Non-SFBT. Many clinics use ORS and SRS and other outcome measures to determine whether therapy is successful. Other less formal ways may involve occasionally asking clients how therapy is going for them or monitoring homework or severity of symptoms.

SBFT. SFBT does not suggest any formal scales to monitor process and progress, but there are many practices that involve checking in with the client at every appointment. For example: starting every session with a variation on "what's better, what's changed, what have you noticed since our last appointment that you are pleased with, how are you coping (if things are worse), etc." SF therapists are also listening for small signs of progress and magnifying them, through questions, to in-crease the chance that the client will be able to take credit for the changes.

Implications

Research Implications

We live in an era where understanding what we do and understanding why it is effective within therapeutic settings is being emphasized, it is essential to be able to articulate in a meaningful way how SFBT is evidence-based. There is significant research that provides empirical support for SFBT (Kim, 2008; Kim et al., 2019) and there is significant process research that increases our understanding of what happens in sessions that might contribute to the abundance of positive outcome data (Franklin et al., 2017). However, understanding the research that supports the common factors and understanding where the common factors align with SFBT will further broaden the evidence-base of SFBT.

First, the utilization of a treatment manual strengthens the foundation of the evidence-base for a particular therapeutic approach, because it increases the likelihood that various clinicians are doing the same thing and it increases the likelihood that one clinician practices consistently with various clients (Trepper et al., 2012). Ensuring that the utilized treatment manual is consistent with best-practices and empirically supported practices is another essential step in understanding and solidifying the evidence-base of an approach. The findings of this study demonstrate that solution focused brief therapy has factors (as identified in Briefer: A SFBT Practice Manual; George et al., 2017) that directly link to each of the identified common factors that are supported by empirical research (See Table 2).

Second, by linking the factors from the SFBT treatment manual to the factors that contribute to effective outcomes across therapeutic modalities, we link our evidence to the broader network of evidence of effective modalities (See Table 1). This allows SFBT practitioners and researchers to assert with added certainty that SFBT is evidence-based. It also allows SFBT practitioners and researchers to also communicate with confidence about how SFBT utilizes the common factors to bring about lasting change with clients; a task that is imperative when advocating for the effectiveness of SFBT with third-party payers, with funding agencies, and with clients.

Third, by making this evidence-based link with the common factors, an avenue is created for SFBT practitioners and researchers to communicate commonalities across therapeutic domains that can lead to greater understanding and acceptance of SFBT as a worthwhile approach (face validity) with various stakeholders. This common language allows SFBT clinicians and researchers to co-construct a new reality with other practitioners and researchers who may not initially see or appreciate the effective work of SFBT. By identifying common ground with other modalities (not advocating that we are doing the exact same things but identifying that different approaches can lead to similar outcomes), we may avoid unnecessary debates and arguments, thereby building relationships of collaboration and mutual respect.

Clinical Implications

One of the goals and purposes of this study was to help SFBT clinicians communicate better with clinicians working from different modalities with a common language about what they are doing that is useful in creating change. We hope that by providing the information in Table 2, SFBT clinicians will be able to not only understand how SFBT fits within a larger framework but will be able to articulate this fit to other non-SFBT clinicians. In addition, the information in Table 3, below, has been provided to help SFBT clinicians conduct self-assessments and engage in dialogue with non-SFBT peers about how various modalities may differ, but can still achieve similar therapeutic outcomes.

In addition to being able to talk with other clinicians about the work we do, it is anticipated that clinicians can use the self-assessment to evaluate their own work and make purposeful decisions about how they can work best and most effectively with clients. It is hoped that SFBT practitioners will integrate their clients' language in meaningful ways to build hope and expectation, to activate resources, to utilize external client factors, and strengthen the therapeutic alliance. By purposefully attending to the common factors and useful mechanisms of change, we believe clients will be better served and positive outcomes will be more likely. When acting purposefully, SFBT clinicians can bring the combined evidence-base of common factors and SFBT to bear with their clients.

Limitations

Although this study provides valuable information about the integration of the common factors and mechanisms of change with SFBT, there are some limitations that should be noted. First, the authors did not include a comprehensive consideration of all the mechanisms of change and common factors literature. Because the purpose of this study was to apply the principles to SFBT rather than provide a comprehensive overview, there may be other factors the authors did not include that could provide added insight or understanding. These additional factors not considered in this paper would likely serve to further strengthen the results of this study.

Second, this study provides a first connection through qualitative means to connect the common factors and mechanisms of change literature to SFBT but does not consider the quantitative correlation or causation of these factors to produce particular outcomes. Additional research is needed to draw these types of conclusions.

Conclusion

This paper sought to demonstrate that SFBT can be strengthened as an evidence-based practice by correlating what is done in SFBT sessions with the larger factors that are known to create effective outcomes. We hope that by illustrating how SFBT utilizes these factors through correlations to the Briefer Practice Manual and by providing a self-assessment tool, SFBT practitioners will be more clear about what they are doing in sessions and why, will be able to communicate these efforts to other practitioners (both SFBT and non-SFBT), and will be more purposeful in helping their clients to achieve lasting change.

Table 3

Self-Assessment and Cross-Modality Discussion Questions

Expectation and Hope	Therapeutic Alliance	Tasks of Therapy	Use of Client Factors	Therapist Effect and Self Regulation	Monitoring Process and Outcome
* How do you inspire hope in your client? * How do you make use of expectancy factors from the outset? * How do clients experience what positive change looks like? * How do you deal with unrealistic hopes? * How do you draw on client strengths and resources to help them achieve their goals? * How early in the session do you recognize those strengths and resources? * In what ways do you draw attention to the client's evidence of competence, past success? * In what ways do you check for any change that has occurred between the initial phone call and the appt. and incorporate it into the first session and therapy process?	* How do you collaborate with clients to find their own goal(s)? * How do you establish a strong working alliance? * What do you do to engage clients in therapy? * How do you engage those that seem unmotivated? * What do you do to provide empathy, genuineness, and respect? How do you tailor these to each client? * In what ways do you express thoughtful appreciation for the clients' problems? * In what ways do you follow/ use the client's language, worldview and culture rather than treatment approach? * In what ways do you identify clients that are not progressing and subsequently re-evaluate your work together?	* What strategies do you use to work collaboratively with your clients to develop their own strategies and tasks that may help them reach their desired outcome? * How often do you notice the ideas/tasks/strategies the client develops are the ones that you can't possibly have thought of and come from their own personal experience? * What do you do that might encourage your client to make use of past experiences that help them change? * How do you help your client see themselves from multiple perspectives? * How do you help your client remove contingencies that interfere with their goals? * How do you deal with issues of safety?	* In what ways do you take into account and use the client's environment and existing supports? * In what ways do you expand on the spontaneous changes that clients experience outside therapy? * How do you draw attention to the importance of the fortuitous events in the lives of the client that have led to change and self-efficacy? * In what ways do you utilize your client's input, participation and involvement to determine directions for therapy? * How do you make sure your client takes credit for change?	* What are your strategies to practice careful listening combined with questions aimed at defining and refining the client's goals for therapy? * How do you maintain emotional neutrality and self-regulation? * What have you put in place to ensure you have the kind of ongoing supervision and professional development that is right for you?	* In what ways have you incorporated the following in your practice: How are you? How are we? How is this? * How often do you check in with your client regarding the quality of your therapeutic relationship and their progress? * Do you use a formal assessment tool or more informal feedback? * How do you describe your process? * How does feedback you receive influence your practice? * How do you follow up to determine if the change your client has experienced is stable and long-lasting?

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