CHANGE FACTORS IN SOLUTION-FOCUSED BRIEF THERAPY: A REVIEW OF THE SALAMANCA STUDIES

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The Salamanca research team has conducted a number of language-oriented studies within a solution-focused family therapy practice and training unit. Two outcome studies demonstrated considerable success at termination and on follow-up, including how clients talked about their problem in the first versus final sessions. Other studies were process-outcome designs, linking specific communicative practices within a session to outcomes. These practices included negotiating goals, discussing pre-treatment changes, seeking and amplifying the details of improvements, giving clients credit for their improvements, continually scaling clients' progress, and avoiding conflictive interactions. Results confirmed their potential value for reducing dropout, increasing compliance with homework tasks, and improving outcomes at termination. The results of this ongoing research have direct implications into practice and training.

Since 1989, the Brief Therapy research team in Salamanca, Spain, has conducted research on the language of Solution-Focused Brief Therapy (SFBT, de Shazer, 1988, 1991, 1994; de Shazer et al., 1986) since 1989. The main interest over the years has been in *process-outcome research*, which studies the therapeutic process in relation to specific therapeutic outcomes (Greenberg, 1986). In addition, there have been two outcome studies and some in-depth qualitative research projects. Thus, this review presents a broad range of methods and data, all aimed at practice and training issues related to language and therapeutic change in solution-focused

interventions: How does therapeutic interaction contribute to continuation in therapy and to therapeutic outcome? Which solution-focused techniques are more useful under which circumstances? What are the best ways of implementing them? How can therapists use language in a more intentional way? Table 1 gives an overview of the research projects included in this review.

OUTCOME STUDIES

Initially, the aims of our outcome studies were to establish a basic quality control of the services provided at the Brief Therapy Center of the Pontifical University of Salamanca and to evaluate the effectiveness of SFBT in this context before undertaking studies of its processes. To this end, two outcome studies (Beyebach et al., 2000; Cortés, Peralta, & Machado, 2007) were conducted, both of which analyzed data from first sessions, last sessions and at follow-up. The final samples

TABLE 1. Overview of the Studies Included in This Review

Study	Focus	Sample
Bailín (1995)	Therapeutic interaction and compliance with homework tasks	32 final messages
Beyebach (1993); Beyebach & Escudero (1997)	Therapeutic interaction and dropout	32 sessions
Beyebach et al., 1994	Content of live supervision phone-ins	69 supervisor phone-ins
Beyebach et al. (2000)	Effectiveness of SFBT at termination and follow-up	83 cases
Cabezas & Salvador (2009)	Impact of solution-focused presuppositions in questions	20 interviews
Cortés, Peralta, & Machado (2007)	Effectiveness of SFBT at termination and follow-up	74 cases
Estrada & Beyebach (2007)	Single-case outcome study with depressed deaf clients	3 cases
García (2005)	Qualitative study of client´s perceptions of SFBT	8 eating-disordered clients and their parents
Herrero de Vega & Beyebach (2004)	Effectiveness of deconstruction	96 sessions
Herrero de Vega (2006)	Dealing with stuck cases	20 cases
Pérez Grande (1991)	Effectiveness of brief therapy at termination and follow-up	95 cases
Rodríguez Morejón (1994)	Goals, pre-treatment changes, and cognitive variables	39 cases
Sánchez Prada & Beyebach (2013)	Qualitative study of the deconstruction process	8 sessions

in these two studies were not large ($N = 83$ and $N = 74$), but the percentage of clients who could be reached by phone for follow-up was high (above 75%). Participants in these two studies, as in all other studies reviewed in this paper, were low- and middle-income White Spaniards. They consulted with a variety of complaints, from depression and anxiety to couple conflict, problems with children or adolescents, eating problems, or drug abuse, among others.

Outcome at Termination and Follow-up

Both outcome studies (Beyebach et al., 2000; Cortés et al., 2007) assessed therapeutic outcome at termination by having independent judges review the language of the clients in videotapes of first and last sessions. At termination, 4 out of every 10 clients were found to talk in the past tense about their initial complaint; the majority reported their complaint was completely or partially solved (65% in Beyebach et al. and 76% in Cortés et al.); and most reported that they had totally or partially reached their goals (82% in Beyebach et al. and 88% in Cortés et al.).

Outcome at follow-up was established by telephone interviews asking clients similar follow-up questions as originally used at the Brief Family Therapy Center in Milwaukee (De Jong & Hopwood, 1996). In addition, clients rated the current state of their initial problem on a scale from 1 (the problem at its worst) to 10 (totally solved). Cases were rated as "successful" at follow-up by three criteria: their follow-up score on this progress scaling question was at least a 5; this score was higher than in the first session; and the client(s) reported that they had not consulted another mental health professional after SFBT. By these criteria, 74% (Beyebach et al., 2000) and 67% (Cortés et al., 2007) of the cases were considered successful at follow-up. Although 36% of clients reported that new problems had arisen since therapy termination, 56% described new improvements after therapy was over.

Degree of Improvement: Progress Scaling Questions

In the first study (Beyebach et al., 2000) the average score on the progress scaling question was 4.2 when asked in the first therapy session, 7.2 in the last session, and 7.1 at follow-up. Cortés et al. (2007) found the same trend, with an average of 4.0 in first sessions, going up to 6.6 at termination, and to 6.8 at follow-up. The latter study also categorized the scale scores for individual cases as De Jong and Hopwood (1996) did 10 years before, comparing the scores in the first and the last session. In the Cortés et al. study, 17% of the cases were categorized as not improved (no increase from first to last session); 55% showed moderate improvements (increase of up to 3.5 points on the scale from first session to follow-up), and another 28% significant improvement (increases of 4 or more points). These results compare favorably with De Jong & Hopwood's (1996) results.

Number of Sessions

The mean number of sessions in the Brief Therapy Center of the Pontifical University of Salamanca was low (4.7 in Beyebach et al., 2000; 4.5 in Cortés et al., 2007). However, findings in both studies suggested that briefer might not always be better, as successful cases usually involved a few more sessions than unsuccessful ones. In Beyebach et al., a greater number of sessions correlated significantly with better outcome at termination, with successful cases involving, on average, 5.8 sessions, and unsuccessful ones 4.2. In the Cortés et al. study, the difference failed to be significant, but the trend was still there. These results are consistent with some other outcome studies on SFBT (MacDonald, 2005).

Dropout

Dropout, defined as the unilateral termination of therapy by cancelling an appointment or not showing up, is usually not considered a relevant topic in solution-focused literature. Consistent with this view, the Beyebach et al. (2000) data showed that, at follow-up, dropout clients were as successful as clients who terminated therapy by mutual agreement. However, some other data suggested that dropout might have more relevance than is usually assumed by solution-focused therapists. Although at follow-up the termination status made no difference in outcome, clients who continued in therapy did improve earlier than the dropouts, and there was some evidence that those clients who terminated unilaterally were not improving in therapy when they dropped out. Also, qualitative data (a telephone interview conducted by an independent researcher with former clients who had dropped out) suggested that, although some clients dropped out because they felt they had improved enough, another substantial proportion left therapy either because they disliked the therapist or the setting or because they felt they were not improving (Beyebach, 1993; Beyebach & Escudero, 1997).

PROCESS STUDIES

Over the years, the Salamanca Brief Therapy research team has also undertaken a number of process-outcome studies to gather information about specific questions on the therapeutic process that arose in the clinical and training practices at the Center. This section will review the major findings of these studies.

Therapeutic Interaction, Dropout, and Compliance with Homework Tasks

An early project analyzed the interactional aspect of therapy dropout. Beyebach, (1993; described in Beyebach, Rodríguez Morejón, Palenzuela, & Rodríguez-Arias,

1996) compared 16 cases in which clients had dropped out with 16 equivalent cases in which clients had continued therapy. All 32 sessions were transcribed and coded with the Relational Communication Control Coding Scheme (RCCCS, Ericson & Rogers, 1973), which operationalizes the relational aspect of communication (Sluzki & Beavin, 1965; Watzlawick, Beavin, & Jackson, 1967).

The RCCCS has three coding levels. First, each speaking turn of the therapist or client is coded for its grammatical form or speech function (e.g., assertion, question, talk-over) and its response mode (e.g., support, non-support, topic change). Next, by combining these two dimensions, the message receives a control code of one-down, one-up, or one-across. *One-up* messages suggest a movement towards dominance in the exchange (e.g., giving an order, changing the topic, or asking a closed question). One-down messages imply seeking or accepting dominance by the other speaker (e.g., complying with an order, accepting a topic change, or giving support). One-across messages move neither towards control nor towards being controlled (e.g., statements that simply elaborate on a given topic, non-committal responses to questions). Finally, combining the control codes of two consecutive speaking turns generates four possible *transactional codes*: *competitive symmetry* (a one-up message by one speaker is followed by a one-up message by the other), *submissive symmetry* (one-down followed by one-down), *complementarity* (one-up followed by one down or vice versa) and *transitional transacts* (any combination with a one-across code).

Using this analysis, Beyebach (1993) found that in dropout sessions clients made more one-up moves toward the therapist, showing more non-support and making more talk-overs than did the clients in continuation sessions. The dropout sessions also had more competitive symmetry exchanges between client and therapist (i.e., Person A made a one-up move, and Person B responded with a one-up move). Finally, dropout sessions also displayed more conflict triads (in which Person A continued the competitive symmetry with a third one-up move). In other words, the interaction in dropout session was more conflictive and less harmonious than in continuation sessions. Initially it seemed that these differences might be due to the therapists' failure to respond appropriately to one-up messages from their clients. However, Beyebach and Escudero (1997) later re-examined the dropout data using sequential lag analyses, and showed that the differences between the dropout and continuation sessions were mostly accounted for by differences in the clients' behaviors, more than by the way that the therapists handled them. Recently, another research team (de la Peña, Friedlander, Escudero, & Heatherington, 2012) studied brief systemic therapy sessions with adolescents and found that therapists in sessions with good therapeutic alliance responded to clients´ one-up, domineering maneuvers in a less domineering way than did therapists in sessions with bad therapeutic alliance.

Bailín (1995) found that a conflictive interaction pattern also inhibited compliance with homework tasks. She studied the therapeutic interaction in final messages, when compliments were given and homework task assigned. When the interaction

was more conflictive (more competitive symmetry and more conflict triads) it was more likely that clients would not carry out the assigned task.

Another implication of these relational communication studies has been to emphasize the value of one-across messages (e.g., assertions that extend the previous message, or non-committal responses that do not attempt to exert control). These messages were more present in continuation than in dropout sessions and also seemed to prevent potential symmetrical escalations. This finding underscores the positive impact of apparently unimportant relationship building, low-key remarks, and small talk.

The results of Markovian chains analysis (Beyebach & Escudero, 1997) also have an implication for practice, as they revealed only first-order dependency between therapist and client messages. *First-order dependency* in Markovian chains means that the turn of each participant in the interaction is statistically related only to the previous turn (whereas second-order dependency would mean that a given depends on the two previous turns, and third-order dependency would mean that it depends on the three previous turns, and so on). This could mean that the development of a viable therapeutic relationship may be more related to how well the therapist's response fits with what the client just said than with some larger communication pattern. This interpretation is consistent with the solution-focused emphasis on listening (de Shazer, 1991) versus strategizing (Tomm, 1987): solution-focused therapists try to base their questions on the immediately previous answers by the client, instead of trying to move the conversation in a pre-determined direction. This is what solution-focused therapists describe as following the client´s lead or "leading from one step behind" (Cantwell & Holmes, cited in Berg & Dolan, 2001, p. 3).

In recent years, research on brief family therapy has confirmed that competitive symmetry in therapeutic interactions is associated with bad therapeutic alliances (de la Peña et al., 2012) and with less engagement in therapy (Cabero, 2004). The implication is that solution-focused therapists should monitor their conversations with clients moment by moment and take any unfolding competitive symmetrical patterns as a sign that the therapeutic alliance might be deteriorating. If such patterns appear, a good antidote might be introducing more one-across remarks, as well as providing more support (de la Peña et al., 2012) and listening more to clients' personal goals (Diamond, Hogue, Liddle, & Dakof, 1999). During the delivery of the final message, clients' oppositional behavior is an invitation for therapists to restrain themselves and not insist on proposing a homework task that is being rejected by their clients.

Therapeutic Alliance from the Client's Perspective

The view of the therapeutic alliance in observable, interactional, and relational communication terms was complemented by a qualitative study from the perspective of the clients in a sample of eight eating disorder cases successfully treated with solution-focused family therapy. García (2005), an independent researcher,

conducted in-depth interviews with clients and their families, asking about their perception of their therapy, of their therapist, and of what had been most useful for them. The interviews were conducted in the families' homes, between one and three years after therapy termination.

The emerging theme of García's (2005) study was that all clients appreciated the close and caring relationship with their therapist. In contrast to their previous therapy experiences, in the SFBT they felt listened to and they perceived the therapist to be non-judgmental and to be working from a nonexpert position. This finding seems to contradict the results of Metcalf, Thomas, Duncan, Miller, and Hubble (1996), who reported that Milwaukee BFTC clients tended to perceive therapists as more directive than the therapists saw themselves, but it is very much in line with solution-focused premises and seems to confirm the important role of the therapeutic relationship in SFBT (Wettersten, Lichtenberg, & Mallinckrodt, 2005). A related finding of García's study was that all clients emphasized that it had been useful for them to receive credit for their contributions and, as one mother put it, "to hear that there were things we were doing right." This foreshadows the findings on pretreatment changes and on positive blaming presented below.

Working on Goals

The co-construction of goals with clients is one of the hallmarks of SFBT (de Shazer, 1991, 1994). An earlier Salamanca study on a more problem-focused Brief Therapy (Pérez Grande, 1991) found that the identification of at least one clear, specific goal in first sessions was associated with a better outcome at termination. Rodriguez Morejón (1994; described in Beyebach et al., 1996) replicated this finding with a sample of 39 clients in solution-focused therapy. Rodríguez Morejón found that cases with well-formed goals were twice as likely to be successful at termination as cases with no clear goals. This finding influenced our clinical work, and we started to pay even more attention to goal setting in first sessions.

In the Rodríguez Morejón (1994) study, clear goals also correlated positively with two cognitive variables, measured before and after therapy using the Generalized Expectancies of Control Scale (Palenzuela, 1988; Rotter, 1966) and the Specific Expectancies of Control Scale (Palenzuela, 1988). Clients who, before therapy, had a more internal generalized locus of control and a higher score on their specific success expectancy (their expectancy that the problem that brought them into therapy would be solved) were more likely to identify clear goals in first sessions than clients who had lower scores on these measures.

Pre-treatment Change

Pre-treatment change, that is, client improvement that takes place before the first therapy session (Weiner-Davis, M., de Shazer & Gingerich, 1987) is another central ingredient of SFBT and was an even better predictor of outcome at termination than

establishing clear goals (Rodríguez Morejón, 1994). Cases where pre-treatment change was reported and discussed were four times more likely to be successful at termination than those with no pre-treatment change reported. At a cognitive level, clients who reported pre-treatment changes showed a more internal specific locus of control and higher success expectancies than those who did not. Although the predictive power of pre-treatment change was not replicated in a later study (Beyebach et al., 2000), there was still a clear trend in the same direction: The success rate when pre-treatment change was identified (77%) was higher than when no pre-treatment change was reported (55%). The value of pre-treatment change is consistent with the relevance that research in psychotherapy gives to clients' pre-treatment factors (Wampold, 2001). For practitioners and teachers, the implication is that any solution-focused first session should identify and discuss improvements that may have already taken place.

Positive Blaming and Amplifying Improvements

In SFBT practice, positive blaming (Kral & Kowalski, 1989) refers to helping clients take credit for their improvements by discussing how they have achieved them. It is assumed that positive blaming empowers clients; in cognitive terms, this would mean that their locus of control becomes more internal (Palenzuela, 1988; Rotter, 1966). In fact, Rodríguez Morejón (1994) found that a more internal locus of control before therapy increased the likelihood of a successful outcome by a factor of three. Also, clients whose locus of control became more internal over the course of therapy were more likely to be successful at termination than those who did not. This finding provides some indirect support to the idea that positive blaming contributes to therapeutic outcome by promoting a more internal locus of control. Recent analogue research by Healing & Bavelas (2011) suggests that questions that presuppose personal agency may play an important role in this process.

Positive blaming implies the need to amplify improvements; that is, to get concrete details of the positive changes that clients report. Supervisors can encourage this practice in their trainees, for example, by phoning in during the supervised session. In an unpublished study of 18 supervised solution-focused sessions, Beyebach et al. (1994) audiotaped and analyzed the supervisor's instructions in 69 phone-ins to the trainee therapists. The researchers analyzed the content of supervisor's instructions. They also coded the verbal interaction between trainee and client(s) within the session (10 speaking turns before and 10 after the phone-in) in terms of problem-focused versus solution-focused utterances. Analysis of these supervisor phone-ins showed that most of them instructed their trainees to amplify and specify more. Moreover, the phone-ins were successful in turning the conversation between trainees and clients in a more solution-focused direction. The effect of this finding at the Family Therapy Center was that we began to train trainees more intensely in amplification skills, in order to ultimately make these phone-ins unnecessary.

Scaling Questions

Scaling questions (de Shazer et al., 1986) have a prominent role in SFBT, especially progress scaling questions as "on a scale from 10 to 1, where 1 stands for the problem at its worst and 10 is that it is completely solved, where would you say things are today?"

Scaling to Assess Progress During Therapy.   Data from two studies in Salamanca supported the notion that progress scales are indeed a useful tool to obtain outcome feedback from clients. Herrero de Vega (2006) found moderate but significant correlations between the progress scale scores and scores on the Outcome Questionnaire (OQ45; Lambert et al., 2002) for second, third, and fourth therapy sessions. In a single-case design study replicated with three different depressed deaf clients, Estrada and Beyebach (2007) documented a close co-evolution of the clients´ scores on the progress scale and the scores on an adapted version of the Beck Depression Inventory (BDI; Beck & Steer, 1993).

Scaling to Assess and Predict Therapy Outcomes.   Cortés et al. (2007) found that an increase on the progress scale score over the course of therapy was associated with successful outcome at termination as measured by independent judges. A study on stuck cases in SFBT (Herrero de Vega, 2006) found that cases that had not increased their progress scaling score by the third session could indeed considered to be stuck on the basis of a variety of other measures, a finding consistent with recent research on therapeutic progress in psychotherapy in general (Lambert, 2010). Stuck cases were very likely to end up as therapeutic failures, especially if they were stuck at low scores (3 or less) on the progress scale. A practical implication of these findings is to scale progress in each and every session, even when there is not enough session time to fully work with the scale scores. Just getting the answer provides useful feedback to the therapist on the progress of the case.

Deconstructing Client Reports of No Improvement

Solution-focused therapists usually ask "What's better?" at the beginning of every session. As noted above, if improvements are reported, their details are amplified and clients are encouraged to take credit for them. If clients see no improvement, the initial report of no-improvement is deconstructed (de Shazer, 1988) through a complex and delicate process in which the therapist tries to generate doubts about the all-encompassing "no improvement" frame and to amplify the description of any small changes that were going unnoticed under it. This process is successful if, as a result, the client is able to identify improvements in spite of his or her initially negative perception.

   A preliminary study by Reuterlov, Lofgren, Nordstrom, Ternstrom, and Miller (2000) raised doubts about the efficacy of deconstructing reports of no improve-

ment. However, Herrero de Vega and Beyebach (2004) replicated Reuterlov et al.'s method with 96 solution-focused sessions and found that a small but clinically relevant percentage (37%) of the 96 sessions that started with the client reporting no improvement actually ended up with the client identifying and discussing improvements. These findings imply that it might be worthwhile to try to deconstruct initial no-improvement reports as a first option before considering a radical change of approach.

Sánchez Prada (2008) undertook an intensive, qualitative study of eight solution-focused sessions, seeking a model of successful deconstruction. His study confirmed that deconstruction is a complex process in which the deconstruction of no-improvement interacts with the construction of improvements (see Sánchez Prada & Beyebach, in this issue).

Solution-Focused Presuppositions

A final area of research has been the effect of solution-focused language, specifically in therapists' questions. Over the past ten years, training at the Salamanca Center has followed the solution-focused tradition of encouraging trainees to use solution-focused questions, with embedded solution-focused presuppositions. For example, "What is better?" asks explicitly about recent improvements, but it also carries the presupposition that they are likely to have happened, in contrast to "Is there anything better?" or the even more neutral "How are you doing?" These questions have been described elsewhere as constructive questions (McGee, 1999; McGee, Del Vento, & Bavelas, 2005).

Questions with solution-focused presuppositions should increase the likelihood of solution-focused answers. However, in our study on deconstruction (Herrero de Vega & Beyebach, 2004), there was an incidental finding that clients' answers to openings with solution-focused presuppositions versus to openings without solution-focused presuppositions did not differ in the expected direction. Clients who were asked "What is better?" were not more likely to report improvements than those who received the less solution-focused question "How have things been these weeks?" This result is in line with the study by Throckmorton, Best, and Alison (2001), who found that a prompting task during initial phone calls did not increase the likelihood of pre-treatment changes in first sessions.

This intriguing finding, which contradicted solution-focused clinical lore, led to an analogue study that specifically tested the effect of questions with solution-focused presuppositions versus questions with non-solution-focused presuppositions. Cabezas and Salvador (2009) interviewed 20 medical residents about their resources and strengths as they moved to a new city. During the interview, 10 participants received only questions with solution-focused presuppositions, while the other 10 received only questions with non-solution-focused presuppositions. Clients in both groups answered the progress scaling question before and after the interview. The hypothesis was that clients in the solution-focused

group would increase their scale score more than clients in the other group, but again no difference was found.

SUMMARY

Altogether, the main findings of the Salamanca studies offer empirical support for a variety of solution-focused practices and principles. They confirm that SFBT is usually brief and effective, but also suggest that in some cases more sessions might be better (Beyebach et al., 2000; Cortés et al., 2007), and that client dropout can constitute a clinically relevant problem (Beyebach, 1993). Clients indeed perceive and value the collaborative relationship that solution-focused therapists try to create (García, 2005), a relationship that promotes continuation in therapy (Beyebach, 1993) and compliance with homework tasks (Bailín, 1995). There is also some indirect support for following the client´s lead, which is typical of solution-focused therapists (Beyebach & Escudero, 1997).

There is also evidence that several specific solution-focused techniques have a positive impact on therapeutic progress, including negotiating goals (Rodríguez Morejón, 1994), discussing pre-treatment changes (Rodríguez Morejón), and using scaling questions (Herrero de Vega, 2006) as well as some evidence on how these techniques should be used. Getting specific details in therapeutic conversations seems to make a difference (Beyebach et al., 1994), as does ensuring that clients take credit for their improvements (Beyebach et al.; Rodríguez Morejón), as solution-focused authors have predicted (e.g., de Shazer, 1991, 1994; Kral & Kowalski, 1989) and as other researchers have established for other treatments (e.g. Powers, Smits, Whitley, Bystritsky, & Telch, 2008).

Finally, a number of our findings support the important role of listening carefully to the clients and trying to adjust to their position: Therapists would be well-advised to pay close attention to signs of client opposition (Bailín, 1995; Beyebach, 1993), to regularly ask them for feedback on therapeutic progress (Herrero de Vega, 2006), to check the relevance of therapeutic improvements for the clients, and to listen to negative reports before trying to deconstruct them (Sánchez Prada & Beyebach, in this special section).

Some of the Salamanca results also draw attention to the weight and influence of client factors. For example, there was the predictive value of internal locus of control, a cognitive feature that was measured before therapy started in the Rodriguez Morejón (1994) study. However, note that successful clients increased their internal locus of control during therapy (Rodríguez Morejón, 1994; described in Beyebach et al., 1996), a finding that implies that this client factor can be influenced. The importance of client factors also appeared in the finding that what predicts a bad therapeutic outcome is not so much how the therapist responds to the clients' domineering one-up moves, but the proportion of such moves clients make in the first place (Beyebach & Escudero, 1997).

The centrality of client factors may also be the reason why solution-focused presuppositions in opening questions failed to have an immediate impact on clients' responses (Herrero de Vega & Beyebach, 2004). This reading of the data appears to be inconsistent with the traditional solution-focused interest in the therapist's technique, but it fits well with the solution-focused emphasis on clients' resources and the view of clients as the real experts. Seen from a broader perspective, our findings are also consistent with Bohart's (2006) view of psychotherapy as a process that does not consist of therapists operating on passive clients, but rather of clients actively operating on the techniques and therapists' inputs.

There are, of course, both strengths and limitations of the body of research reviewed here. The studies are a rather heterogeneous group of naturalistic studies that combine quantitative with qualitative, published with unpublished, process-outcome with outcome-only studies. Therapy was conducted both by experienced therapies and by trainees, with clients that varied widely in their demographic and clinical features. In spite of this diversity, most studies were conducted in the same setting, so the extent that the results can be generalized beyond the specific characteristics of Spanish and university-based samples is an open empirical issue. Although our results show a remarkable convergence, most of them have not been replicated yet.

Future studies should tackle some of the issues our research has raised. First, what is the best way of getting and specifying behavioral descriptions from clients? It would be useful to develop clear guidelines on how to do this, especially with clients who have difficulty giving specific information. Second, what is the best way to engage in the process of positive blaming (Kral & Kowalski, 1989)? Maybe there are more productive ways to discuss how clients have produced their improvements; that is, better options than the traditional "How did you do that?" question (de Shazer 1991, 1994). Third, the use of questions with solution-focused presuppositions also merits further study. The use of microanalysis (De Jong, Bavelas, & Korman, 2013) to analyze the effect of questions and other interventions on real clients within actual therapy sessions may confirm the therapeutic relevance of these findings. Finally, in the near future our research group would also like to move beyond therapeutic conversations and study the additional benefits that homework tasks might produce in solution focused therapy.

CONCLUSIONS

What is the view of change factors in SFBT that emerges from this body of results? Our findings support the broader notion that SFBT has a therapeutic impact because of the relationship that clients and therapist co-construct, a relationship in which clients feel listened to and respected, are reinforced in their successful solutions and are supported in their resources. Therefore, it is worth spending time discussing with clients, in detail, their present and future improvements and their goals. Scaling questions like the progress scale seem to be useful for promoting

these conversations: they generate feedback that helps the therapist ascertain which changes are or are not relevant for therapy, provide an early warning when clients are not progressing adequately, help clients see their improvements, and promote a more internal locus of control.

Seen from a common factors perspective that emphasizes what all effective therapies share (Frank, 1973; Sprenkle, Davis & Lebow, 2009; Wampold, 2001), our data are consistent with the view that SFBT provides a process that allows therapeutic common factors like client contributions, the therapeutic alliance or client expectancy to emerge to their best advantage. From this point of view, solution-focused techniques might work by promoting a collaborative alliance and making best use of what clients bring in at the beginning of therapy: the changes they have already made, their positive expectations of therapy and their view of themselves as potential agents of change. In our view, solution-focused techniques promote in very specific and intentional ways the therapeutic factors that in other therapeutic approaches are often considered unspecific or beyond the control of the therapist.

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