HANDBOOK OF SOLUTION-FOCUSED BRIEF THERAPY

Scott D. Miller,
Mark A. Hubble,
Barry L. Duncan,
Editors

Jossey-Bass Publishers
San Francisco

CHAPTER THIRTEEN

RESEARCH ON THE PROCESS OF SOLUTION-FOCUSED THERAPY

Mark Beyebach, Alberto Rodríguez Morejón, David L. Palenzuela, and Jose Luis Rodríguez-Arias

This chapter offers an overview of the research undertaken by the Salamanca Group over the last ten years. This research has been developed around the brief family therapy program of the Universidad Pontificia in Salamanca, where both clinical services and graduate and postgraduate training in solution-focused brief therapy are provided. This intersection of the academic and the professional, of clinical practice and training, impacts our research efforts in several ways. On the one hand, it impacts our own therapeutic practice and training procedures. Our research emerges from specific questions that at one time or another members of our team have asked themselves; the research intends to provide specific answers, or at least to generate new, useful questions. On the other hand, given that students and trainees carry out many of the research tasks, the dual focus of the program also has an immediate impact on the skills of the trainees. For instance, using a coding scheme to analyze therapeutic interaction usually has the beneficial "side effect" of sharpening certain perceptual skills in real therapy situations.

Finally, our academic environment has probably also had an effect on the kind of research we have undertaken. As this chapter shows, we are engaged in what could be described as fairly traditional research: it is nonparticipative, undertaken "from behind the one-way mirror," and, albeit naively, tries not to influence the therapeutic process it is exploring. It relies heavily on traditional scientific notions such as reliability and validity, and does not shun statistics. Within

this traditional framework, however, we have clearly opted for what has been called "process research" (Kiesler, 1973; Greenberg & Pinsof, 1986), which in our view holds the greatest promise of becoming, as we like to call it, "useful" research. In other words, we are basically interested in the process of change as it unfolds during the course of therapy, especially its relationship to the interaction taking place between therapists and clients.

This interest has been translated into three different but complementary lines of inquiry, two of which we describe in this chapter. The first line addresses the *relational process* of therapist-client interaction and its association with therapeutic outcome and with various clinically significant processes such as premature termination of therapy, task compliance, and patterns of conversation displayed by novice and expert therapists. In the first section of this chapter we offer a general overview of our results and a more detailed description of one of the studies we have undertaken within this line of research. The second line of inquiry provides a *cognitive reading* of the process of change in solution-focused therapy. In the second section of this chapter we present our first results, taking into account both traditional cognitive variables and variables generated within the solution-focused approach.

The third line of investigation involves study of therapeutic conversation from the point of view not of the process but of the *content* of the dialogue. We use two different coding schemes, one derived from Sluzki's (1992) suggestions on how to research narrative transformations, and the other an adaptation of an instrument used originally at the Brief Family Therapy Center, Milwaukee, Wisconsin (Gingerich, de Shazer, & Weiner-Davis, 1987), which in our version discriminates several forms of "problem-talk" and "solution-talk." However, because we are only now beginning to get results on this third approach (Beyebach et al., 1994), discussion in this chapter is limited to the first two research projects.

Certain provisional conclusions can be drawn from this body of research, both in terms of the results we have achieved and in terms of research that remains to be done. In the last section of this chapter we offer our own considerations of these conclusions and we discuss the limitations and shortcomings of our studies and prospects for future research.

Research on Relational Communication in Therapeutic Situations

Our first line of research grew out of our interest in what de Shazer (1991) would call "therapy as a system" and, more specifically, from our curiosity about what happens *between* therapists and clients in the course of brief therapy. We wished

to study this dimension without leaving the basic theoretical assumptions of our clinical work.

The relational communication approach, the "pragmatics of human communication" (Rogers & Bagarozzi, 1983; Watzlawick, Beavin, & Jackson, 1967), offered a convenient framework for this undertaking. This approach assumes that people do not relate *and* talk, but rather relate *in* talk; in other words, their exchange of messages *is* their relationship. In this view, emphasis is placed on the interlocking and reciprocal effects of each interactor on the other. Communication is considered the process by which system members define self in relation to the other and simultaneously create the ongoing nature of their relationship.

One dimension of this cyclic and recursive process is the continuous struggle to define what the rights and privileges of the interactors are. This control dimension of relational communication is best described in terms of constraint or interdependence, with symmetry and complementarity as its interactional poles. This conceptualization is consistent with the social constructionist perspective (Gergen, 1985; Hoffman, 1990), in which therapy is seen as a social construction that is recursively and constantly co-created by therapists and clients.

The relational control approach offers not only a set of premises and theoretical constructs, but also some instruments that provide a theoretically grounded and methodologically sound way of operationalizing those premises and constructs. In 1965, Sluzki and Beavin proposed a coding scheme designed to measure the relational dimension of communication. In the decades that followed, this instrument was modified by several authors (Mark, 1971; Ericson & Rogers, 1973; Rogers & Farace, 1975; Heatherington & Friedlander, 1987), until the Relational Communication Control Coding Scheme (RCCCS) and the Family-Relational Communication Control Coding Scheme (F-RCCCS) were developed. These were applied in different settings, including the study of marital couples, manager-subordinate dyads, and therapist-client interactions (Friedlander & Heatherington, 1989; Friedlander, Wildman, & Heatherington, 1991; Heatherington & Allen, 1984; Lichtenberg & Barké, 1981; Rogers & Bagarozzi, 1983).

Our group started using the RCCCS and the F-RCCCS in the coding of first sessions of brief, Mental Research Institute (MRI) style, problem-oriented therapy (Altuna, Beyebach, Piqueras, & Rodríguez-Arias, 1988; Beyebach, de la Cueva, Ramos, & Rodríguez-Arias, 1990). These studies demonstrated the ability of the instrument to discriminate between different "phases" of the interviews. The studies also produced some intriguing associations between relational control patterns in first sessions and therapeutic outcome at termination.

The picture that emerged showed that first sessions with clients who later dropped out displayed a higher degree of "competitive symmetry" (in which either the therapist or the client tried to control the exchange) and verbal conflict

between therapist and client. These sessions also showed the highest incidence of question/answer exchanges. Conversely, successful cases seemed to be characterized during their first interviews by a predominance of "neutralized symmetry," (that is, by exchanges in which neither the therapist nor the client tried to control the exchange). At the same time, at a monadic level of analysis, therapists in successful cases gave more instructions and orders than in any other group of cases. An unexpected finding was that cases that eventually relapsed showed a high proportion of "submissive symmetry" in their first interviews—a type of interaction we termed "one-down hook" with too much agreement between therapists and clients.

These preliminary findings led us to undertake more specific and better designed studies in order to test, on a more solution-oriented sample, some of the hypotheses that had emerged:

1. *Study A* examined the differences between expert therapists and trainees in terms of their relational communication in first sessions of brief therapy (de la Cueva, 1993). Therapeutic outcome at termination was also taken into account. The findings did not conform to any clear pattern, although it did become clear that there were no relational control differences between those sessions conducted by expert therapists and sessions conducted by trainees. However, a differential analysis by "phases" of the interview (the conversation before the break, or "information gathering," and the "final message" after the break, or "intervention"[1]) did show some differences. The results suggested that in successful cases the relational pattern of these two phases was different, while cases in which the conversation unfolded in a similar manner in both phases were more likely to end up in therapeutic failure or dropout.

2. *Study B* examined the relational patterns of the intervention phase and their relationship to the clients' compliance with the homework tasks that therapists suggested (Bailín, 1995). One interesting finding was that the type of compliance, as defined by de Shazer (1985), was indeed unrelated to therapeutic outcome at termination. As predicted by solution-focused theory, clients who did comply literally with tasks or who modified them did *not* get better results than those who did not perform the assigned tasks at all or who did the opposite. There were differences, however, as far as relational communication was concerned. In particular, there was a higher proportion of competitive symmetry and of conflict triads in intervention phases after which the task was not carried out. Conversely, the highest proportion of submissive symmetry appeared in the intervention phases after which the report on the task was rated by the judges as "vague."

3. *Study C* focused on the association of certain relational communication control patterns with continuation or dropout from therapy (Beyebach, 1993). In the rest of this section we give a more detailed account of this study.

Posing the Problem

All clinicians have been confronted with the fact that some clients with whom another appointment has been made do not show up for the interview. On other occasions, clients refuse to set an appointment for another session, even though the therapist might feel that it is appropriate. This is what traditionally has been referred to as "dropout" or "premature termination." Studies on dropping out from psychotherapy show that the incidence is certainly high, regardless of how it is measured and regardless of the context in which it is studied. In most research studies, the dropout rate is about 25 percent, and in some cases affects more than 60 percent of the patients being studied (Baekeland & Lundwall, 1975; Garfield, 1986). Additionally, most premature terminations occur at the beginning of treatment, after one or two interviews.

From the traditional psychotherapeutic perspective, dropout tends to be considered a negative phenomenon. It implies that a certain proportion of clients do not get a treatment they may have profited from, or that they quit before having benefitted as fully as possible. Some authors have pointed out that dropping out of treatment is a negative experience for most clients (Pekarik, 1983; Persons, Burns, & Perloff, 1988), reinforcing their sense of helplessness (Sherman & Anderson, 1987) and also having a bad effect on the morale of the therapist.

In contrast, for most solution-focused therapists dropout is not considered a problem. One could even argue that for brief therapists there is no such a thing as "premature" termination. After all, it is clients who have the final say concerning the pacing of the sessions and their continuation or discontinuation in therapy. For the solution-focused therapist, a client's decision not to come back to therapy might be construed as the wisest decision the client can make, even a sign of taking charge of his or her own life. In fact, research shows that quite often "dropout" is not equivalent to "therapeutic failure," and that in many cases the opposite is true. One of the reasons for dropout is that clients think they do not need more therapy because they have improved enough or have even met their goals (Buddeberg, 1987; Fiester & Rudestam, 1975; Persons et al., 1988; Presley, 1987; Stahler & Eisenman, 1987; Trepka, 1986).

Our view, however, is that dropout (understood as a client's quitting therapy without his or her therapist's agreement, regardless of the number of sessions that have already taken place) does have some negative connotations. For example, dropping out has negative financial and administrative consequences for treatment professionals (Pekarik, 1983; Persons et al., 1988; Sherman & Anderson, 1987). From a more clinical perspective, dropping out points at least to a lack of "fit" between the therapist and client. After all, we are not talking about a therapist and a client deciding that no more therapy is necessary (something

that in solution-focused therapy quite often happens even after a single session), but about a therapist who fails to recognize that his or her client wants no more therapy and therefore invites him or her for additional sessions, which the client then misses. Finally, and from a research perspective, those clients who drop out and then "disappear" prevent follow-up which in turn hinders therapists and researchers from learning about their clients.

In our view, these considerations make dropping out of therapy an important research topic. However, most research on dropout from therapy has tended to assume that dropping out is essentially something associated with—and due to—certain characteristics of clients. Implicit in this assumption is that certain clients show a tendency to break off from treatment prematurely, regardless of the nature of the treatment. In this way, the influence of factors associated with the course of treatment itself or with the therapist's behavior have been overlooked, and variables such as the sociodemographic characteristics of the subjects or their psychopathology are emphasized (Baekeland & Lundwall, 1975; Bischoff & Sprenkle, 1993).

The poor balance of this type of research has led other researchers to begin to broaden their perspectives (Anderson, Atilano, Bergen, Russell, & Jurich, 1985; Dubrin & Zastowny, 1988; Duehn & Proctor, 1977; Gunzburger, Henggeler, & Watson, 1985; Hardin, Subich, & Holvey, 1988; Mennicke, Lent, & Burgoyne, 1988). Instead of focusing on variables that are static or of limited clinical relevance (demographic, contextual, and psychometric), they have underlined the fact that dropping out does not take place in a vacuum but rather in a particular context and that it is therefore necessary to also take into account the influence of therapists and their work methods. Furthermore, researchers began to take a closer look at the interactional context in which dropping out occurred.

This, then, is the approach we have taken. We have addressed the topic of brief therapy dropout not from study of the more or less intrinsic characteristics of therapists and clients but by analyzing the *interactional context* in which dropping out occurs. We have done this using a methodological approach consistent with the perspective of the pragmatics of human communication (Watzlawick et al., 1967; Rogers, Millar, & Bavelas, 1985) and using the F-RCCCS (Heatherington & Friedlander, 1987) to measure the relational control of communication taking place between therapists and clients during therapeutic sessions.

The core question of our research was *what are the differences between the communication patterns arising in brief therapy sessions after which the client continues in treatment and the communication patterns arising in brief therapy sessions after which the client abandons therapy?* This study tested a set of sixteen hypotheses that were derived from our previous studies as well as from predictions based on various theoretical premises. These hypotheses reflected both monadic and dyadic levels of analysis, as well as the "information gathering" and "intervention" parts of the interview.

In general terms, we expected the therapeutic conversations in the "continuation group" to be fluid, with the client volunteering information and the therapist giving support and producing brief statements to keep the conversation going. We further assumed that there would be fewer question-answer exchanges and fewer overlaps in this group than in the "dropout group," which would result in a higher proportion of transitional transactions in the continuation as opposed to the dropout group. In the dropout group, conversely, we anticipated that there would be less support and more overlaps than in the interviews of the continuation group. We thought that therapists and clients would engage in more question-answer patterns and symmetrical escalations. For these reasons, we predicted that there would be more competitive symmetry and also more conflict triads in the dropout interviews.

The Method

The Sample. The ninety-seven subjects in the study were sampled from cases seen over a three-year period at a private brief psychotherapy center in Salamanca, Spain. The treatment they received at the center can be described as an integration of solution-focused (Berg and Miller, 1992; de Shazer, 1985, 1988, 1991) and MRI problem-focused (Fisch, Weakland, & Segal, 1982) brief therapy approaches. Previous research by a former member of the research team (Pérez Grande, 1991) found that the overall sample had been in therapy for an average of five sessions. At termination, 71 percent of this group of clients reported either the complete disappearance of their complaints or a clear improvement. At follow-up (between six and thirty-five months after termination), 12 percent of the successful cases were rated as relapses, whereas 38 percent of the clients reported that additional positive changes had taken place.

From this population, the sample was selected following a three-step procedure:

1. Location of therapies with individual format (one therapist and one client)
2. Selection of cases of early dropout
3. Selection of a comparable group of interviews after which no dropout occurred

The definition of dropout we used, close to Garfield's (1986) recommendation, results from an exhaustive review of the diverse definitions of dropout appearing in the literature (see Beyebach, 1993). We consider dropping out (or premature termination) to be an interruption of treatment that occurs unilaterally on the part of the client without agreement by or the knowledge of the treating therapist. Dropout may occur because the client refuses to agree to another interview (despite the counsel of the therapist), because the client fails to attend

an appointment (and does not ask for another), or because the client cancels a session and does not set up another one. We further define dropout to be "early" if it occurs after the first, second, or third session.

First, all of the cases with individual format in which dropout did not occur were identified. Sixteen cases were then chosen from the total number by carefully controlling a series of variables to guarantee that they were comparable to the dropout group in dimensions germane to the study. Regarding the therapists, the variables controlled were therapist's gender (male/female) and professional experience (experts/trainees). To control for possible differences in the personal styles of the therapists, each dropout case was matched with a non-dropout case treated by the same therapist. This presented no difficulty in therapies carried out by some of the expert therapists (ten of the sixteen cases). For the cases conducted by trainee therapists (five of the sixteen dropout cases), however, it was necessary to match dropout cases with those of another trainee therapist of the same gender. Finally, the gender of the client and the interview number (first, second, or third session) were also controlled.

The final sample contained thirty-two interviews, sixteen for the dropout group and sixteen for the continuation group. Owing to the design of the study, the dropout and continuation groups did not differ in the gender or experience of the therapists, the gender of the clients, or the number of the interviews analyzed. Additionally, there were no significant differences between the two groups in the age, occupation, or marital status of the subjects. Neither were there significant differences in the type of presenting problem or the basic ineffective attempted solutions (Fisch et al., 1982).

With respect to the clients' perceptions of their problems, the replies to a questionnaire administered before the first interview took place (Pérez Grande, 1991) likewise indicated no significant differences between the dropout and continuation groups regarding either the perceived severity of the problem (mean dropout = 3.61; mean continuation = 3.79; $t = .44$; $p = .67$) or its urgency (mean dropout = 4.38; mean continuation = 4.36; $t = .07$; $p = .945$). Furthermore, there were no significant differences between the groups in the number of clients who had been in therapy previously for the same problem. Logically, there were statistically significant differences between the two groups regarding the length of therapy as measured by the number of sessions received. In dropout cases, clients attended a mean of 1.7 sessions while clients in the continuation group attended a mean of 5.6 interviews ($t = 7.44$; $p < .0001$).

The Measures. We used Heatherington and Friedlander's (1987) F-RCCCS version of the RCCCS. Sufficient data exist concerning the reliability and validity of the R-CCCS and the F-RCCCS for therapy situations (Friedlander, Wildman,

& Heatherington, 1991; Gaul, Simon, Friedlander, Cutler, Heatherington, 1991; Heatherington, 1988).

Using the F-RCCCS involves three steps. The first consists of coding each intervention of the speakers (that is, each speaking turn). Each turn is assigned a three-digit code, based on speaker, format, and response mode. The first digit corresponds to the speaker (1 = therapist, 2 = client), while the second represents the grammatical format (1 = assertion, 2 = open answer, 3 = successful talkover, 4 = unsuccessful talkover, 5 = incomplete, 6 = closed question). The third digit corresponds to the response mode and refers to the pragmatic function of the speaking turn in relation to the immediately preceding one (1 = support, 2 = no support, 3 = extension, 4 = answer to open question, 5 = instruction, 6 = order, 7 = disconfirmation, 8 = topic change, 9 = answer to closed question). Thus, for example, code 123 indicates that the therapist asked an open question by which the previous speaking turn of the client was extended. On the other hand, a code of 232 indicates that the client overlapped successfully, expressing disapproval of the speaking turn of the therapist.

Once independent judges have coded each message, a set of rules are used to transform the three-digit codes into what are called "control codes." Each combination receives one of three possible control codes: (1) one-up messages (or domineering moves), which indicate a movement toward dominance in the exchange (such as questions that demand a specific answer, orders or taking the floor by overlapping); (2) one-down messages (or submissive moves) which suggest movement toward being controlled by seeking or accepting dominance of other (such as questions that seek a supportive response, or obeying an order); and (3) one-across messages (or neutralizing moves), which are characterized by a lack of movement toward control or being controlled and which have a leveling effect (such as statements of continuance, filler phrases, and noncommital responses to questions).[2]

While sounding complicated, the transformation of the three-digit combinations into directions of control is mechanical. Thus, for example, a code of 116 (or 216)—that is, an order in assertion form—always receives a "one-up" control direction. A 121 (or 221) code—that is, a message of support in question form—will always be a "one-down." An example of a "one-across" message would be a 113 code (an assertion that extends the previous message).

The third step in the use of the F-RCCCS involves passing from the monadic to the diadic level, since using the instrument creates diadic categories of control, formed by each transaction or exchange of two interventions. This is the level of analysis on which the classic constructs of symmetry and complementarity (Watzlawick et al., 1967) were described. However, the combination of *three* control directions (instead of the two initially foreseen by Watzlawick and his colleagues) permits the analysis to go beyond the traditional dichotomy and obtain a total of

up to nine combinations (see Table 13.1): three symmetrical transactions, two complementary transactions, and four transitional transactions.

Table 13.2 shows an example of coded interaction, including all the coding steps.

The Treatment. The therapeutic approach used in this sample is an integration of the brief therapy models developed at the Palo Alto Mental Research Institute in Palo Alto, California (Fisch et al., 1982), and at the Brief Family Therapy Center in Milwaukee, Wisconsin (Berg & Miller, 1992; de Shazer, 1982, 1985, 1988, 1991). Basically, the approach can be described as brief therapy that focuses both on solutions and on the complaint pattern. The treatment provided during our research was not yet as purely solution-focused as our later work has become (Beyebach, 1995).

The Procedure. First, interview transcription was carried out by the first author according to the guidelines proposed by Rogers (1979). While time consuming, it does not require any kind of inference by the transcriptionist.

Then, two judges were trained to code the transcribed material with the F-RCCCS. This training was carried out according to the coding manual developed by Heatherington and Friedlander (1987) until an acceptable inter-rater reliability (Cohen's k) was achieved (Cohen, 1960). Each coder went on to code all thirty-two interviews included in the sample. The coders were blind to the hypothesis of the study. The fact that *each* session was coded by the two researchers permitted us to monitor inter-rater reliability throughout the process, ensuring that the k levels persisted at acceptable values throughout (in the case of the sample, at all times above k = .66, with a mean k of .71).

The Results

To compare the relative frequencies of the types of message and the types of transaction, the Z statistic for the contrast of proportions in two independent samples was used (Martín Tabernero et al., 1985). Table 13.3 summarizes the results obtained. (An operational description of each of the hypotheses and a more detailed report of the results obtained can be found in Beyebach, 1993.)

With respect to the analyses carried out on a monadic level for whole interviews, without distinguishing phases, the results conformed to what had been hypothesized. A significantly lower percentage of interventions were coded as support in the dropout group than in the continuation group, as well as a significantly higher percentage of nonsupport and successful talkovers. On analyzing the therapist and client data separately, it was found that for nonsupports and

TABLE 13.1. TYPES OF TRANSACTION FROM THE COMBINATION OF THE CONTROL DIRECTIONS OF TWO CONSECUTIVE MESSAGES.

Speaker 1 Control Code		Speaker 2 Control Code	
One-up	One-up Up-up Competitive symmetry	One-down Up-down Complementarity	One-across Up-across Transitory
One-down	Down-up Complementarity	Down-down Submissive symmetry	Down-across Transitory
One-across	Across-up Transitory	Across-down Transitory	Across-across Neutralized symmetry

successful talkovers the differences between both groups were due to the clients. By contrast, both the therapist and the client contributed to the difference in the proportion of support.

The hypotheses regarding the diadic level of analysis were also verified for whole interviews. In the interviews of the dropout group, a significantly higher percentage of competitive symmetry transactions (one-up/one-up) and of conflict triads (one-up/one-up/one-up) was seen than in the continuation group. The percentage of one-across/one-down transactions (neutralized symmetry) was significantly lower in the dropout group than in the continuation cases.

Analyzing by phase, the expected results were obtained for the information gathering phase of the interview. From the monadic point of view, we found that in the dropout group there were a significantly lower percentage of therapist questions and client replies than in the continuation group. There was also a significantly higher percentage of one-up maneuvers (on the part of both the therapist and the client) and a lower percentage of one-down moves (again, for both therapist and client) in the dropout group.

The hypothesis of expected differences in the proportion of domineering behavior (one-up) of the client (ab = .20; cont = .14; $p < .00001$) was also verified. At the diadic level, there was a significantly higher percentage of complementarity (accounted for by the question/answer exchanges) in the dropout group than in the continuation group. The hypotheses for the intervention phase were not verified, however. For example, there was *not* a lower proportion of complementary transactions in the dropout cases than in the cases of the continuation group, and the percentage of clients' one-ups was also not significantly higher during this phase of the interview.

TABLE 13.2. EXAMPLE OF CODED INTERACTON: THREE-DIGIT CODE, CONTROL DIRECTION AND TYPE OF TRANSACTION.

Dialogue	Message	Control Code	Transaction Direction
Therapist: What's better since we last met?	123	Across	
Client: My husband doesn't like therapy, you know; he is definitely not coming.	217	Up	Transition across/up
Therapist: Well, that's not really what I have asked you.	118	Up	Competitive symmetry
Client: Yes, you are right. I am sorry.	211	Down	Complementarity
Therapist: Never mind. I am sorry, I should not have interrupted you. So, he is not coming.	111	Down	Submissive symmetry
Client: Well, I guess for him there is no point in talking about these things.	213	Across	Transition down/across

In addition to verifying our hypotheses and predictions, some complementary, exploratory analyses were performed that we will only sketch here. First, we divided the dropout group into two subgroups, "successful dropout" (those cases in which the interrupted therapy had been successful and the client-therapist relationship was judged as "good" by both the client and therapist) and "unsuccessful dropout" (those cases in which the interrupted therapy had not been successful and the client-therapist relationship was judged as "bad" by the client). This categorization was done by an independent judge, combining (1) an analysis of the taped interviews, (2) the answers to a questionnaire completed by the clients before the first session, and (3) clients' answers to a semistructured questionnaire conducted during telephone follow-up.

Our hypotheses were tested on these subsamples separately. Although we expected that the hypotheses would hold for the unsuccessful dropout subgroup only, it turned out that both groups showed the same basic pattern of findings. In other words, the interactional nature of interviews followed by dropout (as opposed to interviews followed by continuation) seems to hold for different "types" of dropout, irrespective of their final therapeutic outcome or the subjective experience of the interactors.

Second, we carried out a series of markovian and sequential lag analyses (Gottman & Roy, 1990). After verifying that our sampled interaction showed markovian first-order dependency, we were able to select a homogeneous subsample

TABLE 13.3. VERIFICATION OF HYPOTHESES FOR THE TOTAL SAMPLE.

		Dropout	Continuation	
Hypothesis 1.1 (Whole Sessions)				
Support (dyad)	DR<CO	.24	.29	p<.01
Nonsupport (dyad)	DR>CO	.0194	.0145	p<.01
Successful talkover (dyad)	DR>CO	.12	.10	p<.01
Hypothesis 1.3 (Information Gathering)				
Question (therapist)	DR<CO	.21	.18	p<.001
Answer (client)	DR>CO	.16	.12	p<.0001
One-down therapist	DR<CO	.24	.26	p<.05
One-up therapist	DR>CO	.25	.23	p<.05
One-down client	DR<CO	.35	.39	p<.01
One-up client	DR>CO	.20	.14	p<.0001
Hypothesis 1.5 (Intervention)				
One-down client	DR<CO	.44	.49	p<.05
One-up client	DR>CO	.19	.16	n.s.
Hypothesis 1.2 (Whole Session)				
One-up/one-up	DR>CO	.053	.037	p<.01
One-across/one-down	DR<CO	.22	.26	p<.01
Conflict pattern	DR>CO	.013	.008	p<.01
Hypothesis 1.4 (Information Gathering)				
Complementarity	DR>CO	.18	.15	.01
Hypothesis 1.6 (Intervention)				
Complementarity	DR<CO	.23	.25	n.s.

Note: DR refers to the dropout group, CO to the continuation group; n.s. = not significant.

on which to perform sequential lag analysis. This analysis showed that the pragmatic effect of the interactors' messages was the same for both dropout and continuation cases. In other words, one-across messages tended to elicit more one-across messages, while one-up and one-down messages tended to inhibit one-across messages and instead elicit one-down or one-up messages.

Discussion

For the group of sixteen interviews after which clients dropped out, fourteen of the sixteen, or the majority of, hypotheses were fulfilled. Though the differences were in the predicted direction, they are in no case spectacular. Rather, they are a series of modest, although consistent, differences that provide a certain picture of how the interaction unfolded.

The differences between the dropout group and the continuation group seem to be mainly related to the information-gathering phase. Consistent with previous findings (Beyebach et al., 1990), the data show that the "question/answer pattern" occurred with greater frequency in those interviews after which the client dropped

out of treatment than in those after which the client continued in therapy. This form of interaction has also been described by Heatherington and Allen (1984), who note that "the cross-fire of questions and answers" is a type of exchange that produces a feeling of discomfort and competition between the participants. Additionally, in the interviews after which dropout took place, the client interrupted the therapist with much greater frequency (almost double), disapproved more, and gave and received less support than in the interviews of the continuation group. Essentially, the clients in the dropout group were more domineering and insistent on assuming a superior position in the communicative exchange than those in the continuation group.

From the point of view of relational control, the data suggest that therapists from the dropout group do not handle the domineering behavior of their clients adequately and have a difficult time not entering into opposition. Thus, the interviews of the dropout group show a lower proportion of transition patterns with one-down (which would indicate an easily flowing exchange and mutual support), a greater incidence of competitive symmetry, and a higher frequency of the "conflict triad" as described by Millar, Rogers and Beavin (1984). Given this result, it may be inferred that the therapist-client interaction occurring in the sessions preceding dropout has special characteristics—in particular, that the interactions are less harmonious and more conflictual than those after which treatment is continued.

Clinical Implications

Several limitations of the present study should be taken into account when interpreting these findings. First, the sample of the present study is small. In addition, all of the data included in the study were collected at a single site. It should also be remembered that the correlational design of the study and the types of analyses conducted therein never establish *causal relationships* between the independent and dependent variables under study. We cannot say, for example, that the question-answer pattern or the greater presence of conflict triads *cause* subjects to drop out from therapy, since it is possible that some third variable might be responsible for both the type of relational communication patterns observed and continuation in or dropout from therapy.

Bearing these cautions in mind, some inferences can be drawn from the data for the practice of brief therapy sessions:

1. *The question-answer pattern.* The data from this study indicate that an increase in the question/answer pattern is associated with clients dropping out of therapy prematurely. This suggests that therapists would do well to go about obtaining information without provoking the question-answer type of exchange. Of course, this does not mean that an increase in the question/answer pattern is not

the result of a client behaving in a taciturn and uncommunicative way, but rather that it is the job of the therapist to react in such a way that such situations are channeled into more effective interactional patterns regardless of how they might begin. In other words, these data suggest that it is precisely when dealing with uncommunicative clients that therapists should use some technique to prevent the interview from turning into a sterile interrogation. This may occur both through a reduction in the number of questions the therapist asks (for instance, by replacing them with other methods of soliciting information) or by the therapist engaging in some other conversational practices. For example, the data from the sequential analysis indicate that leveling messages (one-across) inhibit one-down and one-up messages (among which questions and answers are included). In fact, the emission of one-across messages elicited leveling sequences in the present study, sequences which different studies have identified as adaptive patterns of communication (Beyebach et al., 1990; Bailín, 1995; Rogers and Bagarozzi, 1983).

Among the types of messages that receive a one-across code and foster the generation of information are conversational skills usually associated with active listening (such as summarizing what the client has said, paraphrasing, extending the contents of the previous message, and so on). Another option is to promote a one-across/one-down conversation pattern (or the inverse), the greater presence of which was associated in the study with continuation in therapy. That is, once the client provides information ("one-across" extensions), use of what Hill (1985) calls minimal stimuli ("Very good," "I see," "I understand," and so forth) to continue extending the topic of conversation. In our opinion, work on stimulus-response congruence (Duehn & Proctor, 1977) supports the positive effect that this type of conversational maneuver has on both satisfaction with the therapeutic relationship and the amount of verbal interaction.

2. *The breakdown of fit: competitive symmetry and conflict triad.* Two other interactional patterns that occurred significantly more often in the dropout than in the continuation group were competitive symmetry and the conflict triad. Our data provide certain tentative ideas about how therapists can avoid these patterns. First, therapists can emit submissive messages when they experience situations of competitive symmetry. This implies introducing complementarity into the symmetry (Watzlawick et al., 1967). Second, as suggested earlier, therapists could meet competitive symmetry with the across-down pattern. This type of transaction seems to be a good way of preventing not only the appearance of sequences of competitive symmetry but also symmetric escalation.

3. *The importance of leveling maneuvers.* The previous two sections point to the possible usefulness of "one-across" maneuvers as ways both to modify the question/answer pattern and to avoid symmetric escalation with clients. In fact, it can

be suggested that these behaviors might be more useful in therapy than excessive agreement with clients, since previous studies carried out by our team suggest that the "submissive hook" (a predominance of one-down/one-down interactions) is associated with both relapse and with vague reports about compliance with homework assignments (Altuna et al., 1988; Bailín, 1995). We believe that these findings about one-across messages point to the importance of what is seemingly secondary in the psychotherapeutic process: neutral comments, "nonevents," or "nontherapy." The data indicate that sometimes what is important in therapy is precisely what tends to be overlooked—that is, the moments in which the therapist does not attempt to dominate or allow him/herself to be dominated, when no attempts are made to introduce change and no preset technique is used. In other words, what Frank (1985) and others have referred to as the "nonspecific" factors involved in the therapeutic relationship.

4. *"Listening" to the therapeutic relationship.* One of the clearest implications to emerge from the results is that therapists (and/or their teams) can use the relational control constructs to evaluate the state of the therapeutic relationship. Indeed, using the relational control constructs of symmetry, complementarity, and transition to describe the actual therapeutic conversation with clients would not only assist therapists to listen to the *content* of therapeutic conversation but also to "listen" to the *process* of that conversation (de Shazer, 1994). This in turn would enhance therapists' ability to reach a communicational "fit" with their clients (de Shazer, 1988).

Research on Cognitive Variables in Brief Systemic Therapy

Another line of research our team has pursued involves the cognitive reading of some elements of solution-focused therapy (Rodríguez Morejón, Palenzuela, & Beyebach, in press). Discussion of some theoretical background and research results follows.

Theoretical Background

We believe that an increasing amount of attention is being paid in the field of solution-focused therapy and brief therapy in general to the role of what in the classic terminology would be described as "cognitive factors" (Zeig & Gilligan, 1990; Gilligan & Price, 1993). Two important epistemological developments have likely been responsible for the increased interest in the study of cognitions (meanings, beliefs, and worldviews).

One development is the introduction of constructivism and social construction theory, both of which cast doubt on the conception of reality as something

objective, unchanging, and independent of the knowing subject (Segal, 1986; Watzlawick, 1984). Within these views, reality is considered something that is created by the subject (constructivism) and meaning is considered a result of social interaction (constructionism). In therapy, such views mean that clients' meanings and beliefs gain ascendancy over therapists'. Logically, therefore, the deconstruction of those meanings and beliefs may be helpful in facilitating the generation of solutions (de Shazer, 1994).

The second development is the use of the narrative metaphor for understanding the therapeutic process (de Shazer, 1991, 1994; Sluzki, 1992; White & Epston, 1989; White, 1995). According to this approach, the material one works with in therapy can be understood as narratives—that is, stories by which people organize their construction of reality and give it coherence. Narratives can be seen as having dual functions. First, they affect the interpretation of new experiences. Second, they affect the future, since they shape people's goals and expectations, and eventually, the way people interact (Markus & Cross, 1990). By changing certain aspects of clients' stories, or the relationship between the various stories, it is possible to modify the way they construct reality, view the future, and ultimately, how they act. As researchers and brief therapists, we are therefore inclined towards a dialogical interpretation of narratives—that is, towards underlining *how* these narratives are created and modified in the course of social interaction (de Shazer, 1994; Sluzki, 1992).

Constructivism, social constructionism, and the narrative metaphor have led brief therapists to consider beliefs and meanings in addition to observable interactions. The interest in cognitive constructs is not new to brief therapy, nor to the related field of systems/family therapy. Indeed, as far back as 1983, Sluzki included cognitive concepts such as "worldviews" in the general systems paradigm and its different applications. Moreover, most therapeutic models, both of family therapy and brief therapy, refer to the importance of clients' worldviews—as something to be either modified or utilized in the process of change (Fisch et al., 1982).

This aspect has received scant scientific attention, however, within the brief therapy tradition. One possible reason for this lack of attention is that the word "cognitive" may seem synonymous with the term "intrapsychic," which for many years has been excluded from the vocabulary of brief therapy. We believe, however, that there is another way of understanding the "cognitive" and the "intrapsychic," which can indeed fit with the assumptions of brief therapy. This view of the cognitive allows us to take advantage of an enormous body of traditional cognitive research and give it meaning within a dialogical or constructionist conception of therapeutic interaction. The following pages are dedicated to outlining this conception.

Understanding Cognitions

Traditional theories frequently attempt to describe what is human on the basis of a series of internal, stable, and difficult-to-modify dispositions. Such models of human behavior are frequently unable, however, to account for the flexibility and creativity with which people adapt themselves to their environment (Mischel, 1968, 1973). For this reason, theorists began to search for more-dynamic models, units that would overcome the structural conception of reality inherent in traditional theories (Cervone, 1991).

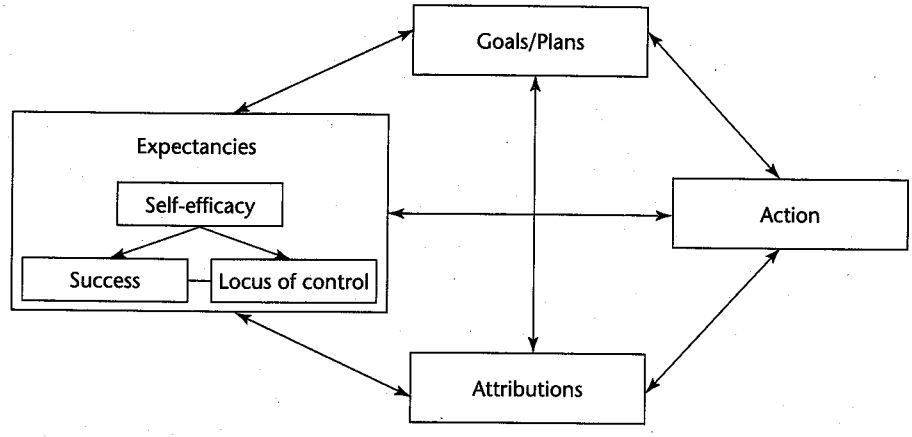
Sociocognitive (Mischel, 1973), or cognitive-propositive units (Palenzuela and Barros, 1993; Palenzuela and Rodríguez Morejón, 1993) are two such dynamic concepts that have come to the forefront. The dynamic and fluid nature of these concepts overcome the static view of most traditional theories; they portray personality as a dynamic system in which people can be described as active, propositive agents who interact in a real and figurative sense with others and the environment and who make free and responsible decisions. These cognitive approaches make it clear that in order to understand people's behavior it is not enough to know what people "have"; one must also know what they can do and in fact do to self-regulate their behavior (Cervone, 1991). It is precisely this type of language—the language of action-oriented cognitions—that we assume and that we shall use to reflect on the intrapersonal dimension of brief systemic therapy.

A review of the cognitive-propositive literature (Rodríguez Morejón, 1994) shows that there are three well-validated variables for understanding human behavior: (1) attributions, (2) goals, and (3) expectancies. To these three variables we add a fourth: action. The relationships among the four variables can be viewed as a system (see Figure 13.1) such that any change in one may lead to modifications in the others.

The studies we address in the following paragraphs focus primarily on one of the four variables, that of *expectancies*. Expectancy can be conceived of as a multidimensional construct (Palenzuela, 1988a, 1988b, 1990, 1993; Palenzuela, Almeida, Prieto, & Barros, 1992) that includes three dimensions: (1) self-efficacy (Bandura, 1989), (2) locus of control (Rotter, 1966), and (3) success expectancies (Rotter, 1954). Self-efficacy expectancies are the estimations that a person makes about his or her abilities to put into operation a given action. Locus of control refers to beliefs of contingency-noncontingency between behavior and outcomes. Success expectancies refer to the estimated probabilities that the desired outcome will come into being.

As a way of illustrating these ideas, consider, for example, that the outcome desired by someone is that his or her problem be solved and that this person asks himself or herself about the possibilities of achieving such a solution. In this case,

FIGURE 13.1. A MODEL OF COGNITIVE SUBSYSTEMS AND THEIR RELATIONSHIPS.



the success expectancy would be reflected in the question: What possibilities are there that my problem will be solved? Conversely, self-efficacy expectancies would be reflected in the question: Do I really feel able to solve the problem? Finally, expectancies of internal-external locus of control would appear as: To what extent is solving this problem related to what I do? A person would have an internal locus of control if they were strongly convinced that the outcomes they desire are dependent upon their actual behavior. In contrast, a person would have an external locus of control if they did not understand that the outcome might be linked to his or her own behavior.

Logically, formulating one or the other type of question and the responses given to it will largely depend on how such questions and answers interact with each other. Thus, from a narrative point of view, this process could be described as one of interacting stories, which to a certain extent shape social interaction but which are also shaped by it. From this perspective, locus of control, self-efficacy, or success expectancies might be seen as relevant "themes" of co-created narratives.

The therapy situation is one setting in which the development of such narratives takes place. In solution-focused therapy, a large part of the conversation can be described as revolving around issues of self-efficacy and locus of control—for example, questions such as "How did you do that?" and "What can you do to get up to six on the scale?" In addition, solution-focused conversation directed toward future achievements and goals can also be seen as emphasizing success expectancies. Consider, for example, the question, "How will that change when the problem is

solved?" These expectancies are also an important part of the therapeutic decision-making process in solution-focused work. For example, the decision to tell clients to "do it more," or to assign a "prediction" task, depends to a great extent on whether client behavior is believed to be deliberate (reflecting an internal locus of control) or spontaneous (reflecting an external locus of control).

Although solution-focused therapists tend to shun cognitive descriptions, we shall try to show that it can be fruitful to bring the cognitive perspective into solution-focused work. In fact, our research project on cognitive variables and solution-focused therapy is committed to this idea, its final aim being to provide a "cognitive" account of the process of change in brief therapy that we hope will enable us to become more effective in helping clients to achieve solutions to their problems. In the following section we report some preliminary findings from the first study we have carried out on this subject.

Empirical Evidence

Posing the Problem. The empirical study we describe shortly explored two questions. The first question concerned the relationship between control expectancies and different clinical variables derived from solution-focused therapy (which henceforth will be referred to as solution-focused clinical variables). The second question addressed the predictive capacity of both control expectancies and solution-focused clinical variables for therapeutic outcome.

Solution-focused therapists use a variety of terms to describe their work. For example, clients are referred to as "customers" when they request from the therapist concrete suggestions for solving their problem. "Pretreatment change" is said to have occurred when families report improvements that have taken place before formal therapy has started. Special emphasis is also placed on "well-formed goals" and whether or not clients have complied with homework assignments.

As solution-focused therapists, we are also aware, however, that "customer" does not refer to an internal characteristic of a particular client's personality but rather is a label that the therapist uses to define the interactional pattern manifested during the session. This interactional perspective makes it clear that the therapist plays a decisive role in the creation of one or another type of pattern. Obviously, the skill of the therapist in establishing a therapeutic alliance will affect the style of the relationship that is established. Likewise, we could say that the appearance of pretreatment change will partly depend on the therapist's asking about such changes at the beginning of therapy, or that the achievement of clear goals will be strongly linked to the conversation developed around, for instance, the "miracle question."

We believe that the decision of the therapist to use a particular solution-focused technique depends on his or her evaluation of the expectancies inherent

in the therapeutic interaction. Accordingly, we believe that it is useful to describe these techniques (client-therapist relationship type, pretreatment change, goals, and compliance with task) operationally and to relate them to control expectancies (self-efficacy, locus of control, and success expectancy).

The second aim of our research project was to test whether the client's expectancies are related to outcome of treatment. Empirical evidence suggests that clients who start therapy feeling more efficacious and in control achieve better therapeutic results (Abramowitz, Abramowitz, Roback, & Jackson, 1974; Breteler, Mertens, & Rombouts, 1990; Craig & Andrews, 1985; Foon, 1987; Scharamski, Beutler, Lauver, Arizmendi, & Shanfield, 1984; Weisz, 1986). However, all of these studies have been conducted in the domain of cognitive and behavioral therapy. For this reason, we wanted to see if the same results were true for solution-focused therapy.

Method. *Sample.* The sample used in this study was comprised of thirty-nine subjects (twenty-one females and eighteen males) who received brief therapy at a public mental health agency. The average age of the subjects was twenty-six years old (DT = 10.6) with the youngest being twelve and the oldest client being fifty-five years of age. Fifty-four percent of the subjects were unmarried, 41 percent were married, and 5 percent were divorced. Forty-eight percent of the treatments were conducted individually, 13 percent were with couples, and 39 percent were family sessions. The sample included ten subjects with diagnoses (according to the DSM III, American Psychiatric Association, 1987, used for research purposes only) of affective disorders, ten with anxiety disorders, three with somatoform disorders, eight with adaptive disorders, four with behavior disorders, three with eating disorders, and one with an education disorder.

The sample was extracted from among the total population of clients who sought care and were seen by the therapist at the center between 1992 and 1993. In a previous study of this population, 10 percent of the clients dropped out after the first session and 80 percent of those who continued beyond the first session were rated (by independent judges) as successful cases at termination (Fontecilla, Ramos, and Rodríguez-Arias, 1993). The average number of sessions was five and the average length of each session was thirty-three minutes.

Measures. Control expectancies were measured at two different levels of specificity/generality using two different instruments (Rodríguez Morejón, 1994). The Generalized Expectancies of Control Scale (GECS), a shortened version of Palenzuela's (1990) Generalized Expectancies of Control Scale, is composed of nine items, three for each of the three expectancy dimensions. As indicated by its name, this scale measures expectancies at a maximum degree of generality. Examples of the items include: "In general I feel very capable" (self-efficacy), "How my life will

go depends on how I act" (locus of control), and "I am convinced that I will be successful in life" (success expectancies).

The second instrument used in the study was the Specific Expectancies of Control for Problem Solving Scale (SEC-PS). This scale also contains nine items with the same distribution as the previous instrument. As the name implies, this instrument is useful for assessing the expectancies of the subjects concerning the solution of the concrete problem that initially led them to seek therapy. Some examples of the items are: "I feel able to confront this difficulty" (self-efficacy), "That I will be able to overcome this problem is closely linked to what I do" (locus of control), and "I believe that in the end this problem will be solved" (success expectancy). Both scales have been subjected to rigorous analyses in both clinical and nonclinical samples and have proved to have satisfactory psychometric properties (Palenzuela, 1990; Rodríguez Morejón, 1994).

The solution-focused variables under consideration in this study were categorized by the therapist in charge of the cases using standardized procedures. For example, the therapist categorized the relationship with the client as being a "customer-type relationship" when the client answered the question, "To get what you want, would you be willing to do anything I ask you to do?" affirmatively and unhesitatingly. This question was asked of the client immediately preceding the break prior to the first session intervention. Similarly, the therapist assessed pretreatment change by asking the client, "From the time when people ask for consultation to when we can see them, some time usually elapses. Many people tell me that during that time things have gotten better. What have you noticed?" The therapist considered that the client's goals for therapy were "well-formed" when the client was able to state at least one behavioral sign of future improvements; if not, the goals were deemed vague. Assessment of compliance with homework assignments was made in the second session based on client report.

A panel of independent judges blind to the hypotheses of the study were used to assess treatment outcome. These judges listened to audiotapes of the first and last sessions of treatment and assigned the subject to the success group when there was behavioral evidence of change (the client spoke of his or her complaint in the past tense or indicated that she or he had reached most of the goals set), or when both the client and therapist talked favorably about the complaint and agreed that no further therapy was necessary.

Treatment. Treatment was delivered by the same therapist for the entire sample. The type of therapy can be described as basically solution-focused with an emphasis on pretreatment change, exceptions to the problem, and the negotiation of well-formed goals. On occasion, the therapist utilized more problem-focused interventions such as introducing small changes in the pattern of the complaint (see, for example, O'Hanlon & Weiner-Davis, 1989) or even trying to change the basic ineffective attempted solutions of the client (Fisch et al., 1982).

Procedure. Baseline measures were taken of the three control expectancies before treatment was initiated. With the exception of assessing compliance with the homework task, all of the solution-focused variables were assessed by the therapist on the break preceding the intervention of the first interview. Treatment outcome was evaluated after the termination of therapy.

Results and Discussion. The correlations between control expectancies (specific and generalized) measured before treatment and the clinical variables are shown in Table 13.4. We found the following significant relationships: (1) pretreatment changes showed a significant, positive correlation with generalized locus of control and self-efficacy; and (2) compliance with homework assignments after the first session was significantly and positively correlated with generalized locus of control. Regarding specific expectancies, there were also some significant, positive correlations: (1) specific expectancies correlated with customer-type relationship and with well-formed goals; and (2) specific success expectancies also correlated with the customer-type relationship. Figure 13.2 offers a graphic plot of the relationships.

Relationship type. The clients who in the judgment of the therapist established a customer-type relationship showed stronger expectancies that their problem would be solved than those who did not, no differences in other cognitive variables being observed. This is an interesting finding since, based on solution-focused theory, we had originally expected that this clinical variable would be related above all to locus of control. The reader will recall that "customers" have traditionally been viewed as those clients who see themselves as part of the solution and who want to do something about the complaint (de Shazer, 1988). In the light of these findings, however, it seems more important to measure clients' expectancies that the problem will be solved than their overall willingness to do something about their problem.

A possible explanation for this finding might be the operation of a third, mediating variable—for example, the client's trust in the therapist. It is possible that our method of evaluating the type of client-therapist relationship contained the implicit question, "How much do you trust me?" Conversely, it seems logical to assume that, to the extent that clients trust the therapist to help them solve their problems, clients' expectancies that the problem will indeed eventually be solved should increase.

Pretreatment change. In the study, subjects who reported improvement prior to the formal initiation of treatment showed a greater generalized internal locus of control and, moreover, a greater generalized sense of self-efficacy. These findings can be interpreted in two ways: (1) subjects scored higher in self-efficacy and showed a more internal locus of control because they had already started to

TABLE 13.4. CORRELATIONS BETWEEN COGNITIVE VARIABLES AND CLINICAL SOLUTION-FOCUSED VARIABLES.

	Customer (N=35)	Pretreatment Change (N=39)	Goals (N=35)	Task Compliance (N=39)
Generalized expectancies				
Global index	.09	.44**	.29	.03
Self-efficacy	–.07	.33*	.19	.08
Locus of control	.20	.53***	.30	.32*
Success expectancies	.08	.23	.21	.12
Specific expectancies				
Global index	.36*	.25	.35*	.21
Self-efficacy	.32	.10	.24	.26
Locus of control	.06	.278	.31	.26
Success expectancies	.36*	.26	.31	.03

*p<.05

**p<.01

***p.001

Note: For all solution-focused variables there are two categories. For "customer" and "pretreatment change" there are "yes/no"; goals can be clear or vague; and compliance with tasks can be literal or not. In any case, the first element is 0 (no, no, vague, not literal) and the second element is 1. Biserial Puntal** correlation was used. "Global index" is the summatory of the three expectancy variables.

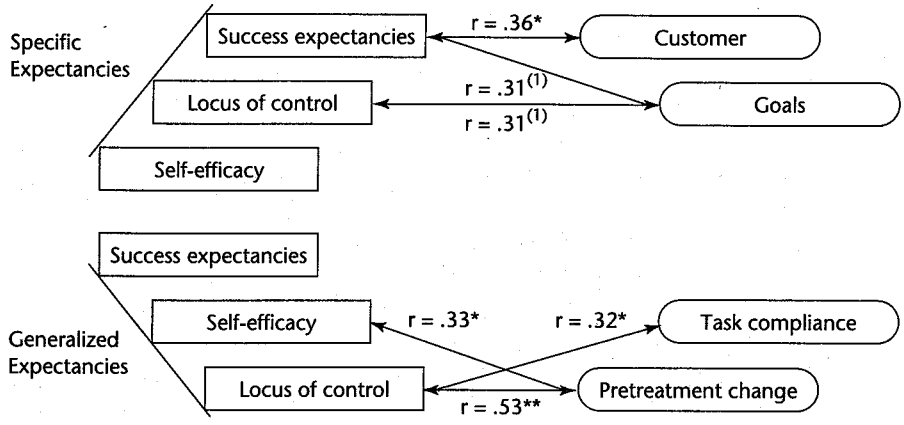
Source: Rodríguez Morejón, A., Palenzuela, D. L., & Beyebach, M. (1996). Copyright 1996 by Editorial Fundamentos. Used with permission.

experience improvements, or (2) subjects began to improve without the help of the therapist precisely because they felt more capable and because they believed that what happens to them depends on their own behavior.

We are inclined to believe the second interpretation—that is, that clients who believe they are more capable and who anticipate contingency between their behavior and the desired outcome are more likely to experience and report pretreatment change. The reasoning on which we base our belief is that if increases in the two types of expectancy were a consequence of pretreatment change, then the increases should be more apparent in the specific rather than the generalized expectancies. Recall that generalized expectancies are by definition more global and stable (Rotter, 1990) whereas specific expectancies are more specific and modifiable (Bandura, 1989). Our research has established, however, that quite the opposite is true.

Additionally, pretreatment change is a phenomenon that is constructed in the conversation that occurs during the session. As such, pretreatment change only

FIGURE 13.2. BISERIAL PUNTAL CORRELATIONS BETWEEN CONTROL EXPECTANCIES AND CLINICAL VARIABLES.



Note: (1)p<.06; *p<.05; **<.01.

Source: Rodríguez Morejón, A., Palenzuela, D. L., & Beyebach, M. (1996). Copyright 1996 by Editorial Fundamentos. Used with permission.

begins to be relevant to the client after talking about it with the therapist. Since on most occasions pretreatment change is not considered relevant by the client before therapy has begun, it is hard to conceive that it would be responsible for the increase detected in generalized expectancies. For these reasons, the most parsimonious interpretation of the data is that people who *a priori* tend to describe themselves as capable (high generalized self-efficacy) and as being able to affect outcome through their behavior (internal locus of control) are more likely to engage in effective solution attempts that when discussed with the therapist during the session are then construed as pretreatment change.

Goals. The research also found that well-formed goals were related to specific control expectancies. In particular, subjects who in first sessions were able to establish concrete goals tended to have higher scores on specific locus of control and on specific success expectancies. Negotiating well-formed goals should be thought of as a process that occurs when clients feel that solving their problems will depend on themselves, and when clients have high hopes that their problems will be solved.

The relationship between locus of control and well-formed goals can be interpreted in two ways: (1) having well-formed goals makes people feel that achieving their goals will depend on themselves, or (2) the more responsible people feel for future changes, the more well-formed their goals will be. In this case, we do

not find any advantage in favoring one position over the other. The practical outcome is that it might be helpful to use therapeutic techniques that promote a more internal locus of control with those clients who have difficulty establishing well-formed goals.

One way of understanding the relationship between success expectancies and well-formed goals is that therapists will be more likely to generate clearer goals with clients who show higher success expectancies. Our data seem to go beyond the statement of Garland (1984), according to whom success expectancies are related to the extent to which subjects commit themselves to goals. In our study, the greater the success expectancies, the greater the likelihood that subjects will formulate concrete goals for therapy.

A plausible interpretation of these crossed relationships is that one of the factors that may influence subjects' committing themselves to goals is precisely the clarity with which the goals are established. Thus, the more clearly goals are defined, the greater the probability that the subjects will commit themselves to them. This conclusion would perhaps support the usefulness of future-oriented techniques as therapeutic tools, not only in helping clients clarify their goals for psychotherapy but also in promoting commitment to achieving those goals.

Compliance with tasks. Finally, the results of this study show that people who fulfilled homework assignments tended to have an internal locus of control. These findings seem to contradict the work of Foon (1989), since in our study it was precisely those subjects who believed that outcome depends on their own behavior who complied with the prescriptions of the therapist. We believe, however, that no such contradiction exists. The results of the present study can be interpreted in two different ways: (1) that subjects with an internal locus of control feel that outcome depends on what they do, or (2) that subjects with an internal locus of control allow the therapist to decide what they have to do to begin the change process. Whatever the reason, the important finding is that clients with an internal locus of control believe that *they* must "act"—even if guided by the therapist.

In summary, the study showed that clients who establish a customer-type relationship are those who trust the therapist most and whose success expectancies are therefore higher. In addition, the study found that clients who score highest on internal locus of control and self-efficacy tend to show improvements before therapy as compared with those scoring lower. Also, those clients who establish clear goals are those with higher success expectancies with respect to the problem and with established beliefs that the solution to the problem depends on their own behavior. Finally, the study found that subjects who comply with homework assignments have a higher internal locus of control.

Predictors of Therapeutic Outcome

To determine whether any of the three measures of expectancy were related to treatment outcome, a logistic regression with treatment outcome (success/no success) as the dependent variable and the initial generalized measurements of self-efficacy, locus of control, and success expectancies as independent variables was conducted.

Only one of the three variables, locus of control, was significantly related to treatment outcome ($R = .276$, $p < .01$). In this regard, subjects with an internal generalized locus of control were three times more likely to have a successful treatment outcome. Locus of control continued to predict outcome even when the effects of other cognitive variables (self-efficacy and success expectancies), sociodemographic variables (age, gender), and clinical variables (customer-type relationship, type of goals, compliance with homework assignments, and treatment format) were controlled. Only pretreatment change seemed to decrease the predictive value of locus of control. Indeed, in this study, pretreatment change was also significantly related to treatment outcome ($R = .261$, $p < .05$). Specifically, subjects displaying pretreatment change were four times as likely to finish therapy successfully (Rodríguez Morejón, 1994). By contrast, the presence of clear goals increased the likelihood of a successful therapeutic outcome by a factor of two.

From a constructivistic, nonessentialistic point of view, the predictive capacity of pretest general locus of control is an intriguing finding. After all, the results of this study imply that treatment outcome is largely dependent on features that clients show before therapy begins.

We prefer to emphasize a more interactional view of the process. Consider, for example, that people who show a more internal locus of control on pretest get better therapeutic results because they tend to have actively searched for and developed solutions on their own before therapy starts. If the therapist then highlights and amplifies these pretreatment changes during the first session, the probability of therapy being successful increases. In addition, the active solution-searching behavior of these clients leads them to accept and follow the suggestions they may receive from their therapist, complying literally with the tasks they are given.

Results from other studies further caution against viewing locus of control as a static quality of clients. These results show that locus of control is variable and becomes more internal over the course of successful therapy (Rodríguez Morejón, 1994).[3] This lends support to the notion that the task of solution-focused therapists is to foster situations in which clients experience a better sense of control over their own lives.

Clinical Implications

Many implications for clinical practice can be drawn from the results of this study. However, given that this is the first study of its kind, the data should be treated with caution. For this reason, the generalizations that follow are probably best considered tentative suggestions or working hypotheses that require further research to establish their veracity.

First, the data point out that the three cognitive variables we studied show some association with solution-focused clinical variables. This association might allow a "solution-focused reading" of these fairly traditional variables and, vice versa, a cognitive reading of solution-focused concepts. Such a reading might help brief therapy practitioners recognize the value of cognitive research for the practice of brief therapy. Clinical ideas such as "promoting expectations for change," "positive blame," and "doing what works" are not unlike more-scholarly variables that have been studied for decades by cognitive researchers.

A second relevant finding is the predictive ability of pretreatment change. Our data suggest that generally speaking it might prove especially useful to focus on pretreatment changes in the first session of therapy. More specifically, the data may even lend some provisional support to the idea that discussing pretreatment changes with our clients may be more helpful in terms of therapeutic outcome than working on goals in first sessions. To be sure, the data have moved our own clinical practice in first interviews away from a heavy emphasis on the miracle question (and other future-oriented techniques) and toward pretreatment change (Rodríguez Morejón & Beyebach, 1994). Our training procedures have also moved in the same direction.

Third, the strong relationship between locus of control and treatment outcome lends indirect support to the idea that one task of solution-oriented therapists is to foster a sense of control in their clients. In other words, our data indicate that while it may be good for clients to discover what works, it might be even better for them to discover that they can *make it work*. The results could also be used to predict those clients who will not succeed in solution-focused therapy. In this regard, those clients whose self-description reflects an external locus of control or with whom the therapeutic conversation fails to increase an internal locus of control may be more likely to experience failure in solution-focused therapy. In our opinion, this possibility certainly warrants further investigation.

Finally, the results of the present study also emphasize the importance of well-formed goals. In particular, the results lend support to the idea that the construction of well-formed goals helps to enhance commitment to the process of therapy. They also point to the usefulness of fostering a more internal locus of control when there are difficulties in getting a clear description of goals ("So how will

you do that?"), and vice versa, resorting to goal-related questions as a way to enhance internality.

In summary, the results of this research project provide some empirical support for three basic practices of solution-focused therapy; namely, amplifying pretreatment change, negotiating well-formed goals, and empowering clients by giving them credit for change. All of these practices were found to be related to therapeutic outcome at termination.

Conclusion

We have tried to provide an empirical account of certain therapeutic processes from three very different perspectives: (1) the relational aspect of communication, (2) cognitive variables, and (3) solution-focused theory and practice. We hope we have shown the utility of using such divergent approaches in evaluating solution-focused work.

Overall, the research reported in this chapter provides some empirical support for the idea that certain solution-focused topics of conversation (pretreatment change and goals) are indeed relevant to treatment outcome, and that certain ways of approaching these topics (certain patterns of conversation) are related to both continuation in therapy and compliance with therapeutic tasks. This suggests that it is not only useful in therapy to focus on certain topics, but it is also useful to do so in a prescribed way (that is, both content and conversation process do matter).

Moreover, our results provide a certain empirical underpinning for some of the central tenets of solution-focused therapy. For example, they point to the relationship of pretreatment changes and clear goals to therapeutic outcome, as well as to the negative effect of confronting clients. They also provide support for solution-focused therapists' commitment to promoting clients' internal locus of control.

In addition, the results confirm that compliance with tasks is best understood in relational terms and that therapy can be successful even when the clients do not comply with the tasks they are assigned (Bailín, 1995). Finally, the data provide some new, tentative guidelines for clinical decision making. For instance, they suggest that in general focusing on pretreatment changes might be more productive than working on goals. They also suggest the importance of what others have called nonspecific factors in therapy, and that too much agreement with clients might be less productive than previously thought.

We certainly expect that future research along these lines would improve and clarify these findings. In this regard, we suggest that future studies not only consider outcome at termination but also at follow-up. We also believe that some of the tentative conclusions we have drawn should be subjected to a more focused

research process. Specifically, it would be interesting to study the immediate impact of certain conversational practices or therapeutic techniques on the variables we studied. This should be done at different moments of the therapeutic process in order to obtain a more accurate account of the process of change as it unfolds over time. At the methodological level, statistical procedures such as sequential lag analysis, and research paradigms such as event-analysis, seem to us to be the most promising for future research. They would help us to keep research connected to theory, training, and clinical practice.

Questions from the Editors

1. *Given the constructivist leanings of some solution-focused thinkers, there has been a bias against empirical research. Could you please comment?*

We think that, in fact, this bias not only reflects the impact of constructivist and constructionistic thinking in our field, but it is also closely linked to the general distrust between researchers and clinicians that has existed almost from the beginning of psychotherapy research. We might even say (but we do not) that the narrow-minded reading of constructivistic ideas has simply provided an elegant alibi to those clinicians who dislike the idea of conducting research or of submitting their practices to it.

In our view, constructivism and constructionism should not cast doubts on the possibility of doing meaningful empirical research. They should, however, make us wonder what kind of research we want to call "empirical" and what kind of research is meaningful for clinicians who describe themselves as constructivists or constructionists. We think we should not dismiss empirical research as a futile academic exercise but should try hard to find (or develop) research practices that fit into our theoretical models.

2. *What are you investigating in your present research?*

We are studying the shifts from problem-talk to solution-talk and vice versa using a coding scheme we have adapted from earlier research by Gingerich and associates (1987). At the same time, we are taking a closer look at the shifts that occur *within* problem-talk. For this we are using a measure developed by Sluzki (1992).

3. *How do researchers deal with a model like solution-focused therapy that keeps changing and evolving over time?*

On first thought, we might say "badly." Indeed, the gut feeling is—and we think it is a feeling shared by many researchers—that research is always lagging behind clinical practice, always trying to catch up in vain with the developments that take place in the therapy room. On second thought, however, it turns out that things are not so negative. In our view, the changes in the solution-focused model have not been so radical as to invalidate the present research efforts. Certain techniques or specific practices have kept on evolving, but the basic theoretical assumptions have stayed stable. Therefore, one way to deal with the research-practice time lag is to keep the research focused not on specific techniques but on those more general aspects of the approach—elements like the therapeutic relationship, communication processes, cognitive changes in the course of therapy, and so on. Finally, we should say that it is a good thing that the approach continues to evolve and change—not only on the basis of clinical and theoretical developments but also on the basis of research. That is what we hope we are accomplishing with our work.

Notes

1. These denominations are certainly inaccurate, because we see any therapeutic interaction as intervention. Although it might be more accurate to talk about the "conversation" and the "final message" parts of the interview, we will stick to the shorthand "information gathering" and "intervention," which we have used in previous publications.
2. It should be stressed here that the pragmatic conception of control is different from the classic notion of "power." Accordingly, the following should be taken into account. First, relational control is always an *interpersonal* phenomenon, codefined by the interacting participants. Therefore, it is not a property of individuals but rather of social systems (Rogers-Millar & Millar, 1979). In other words, a subject may propose a given manner for defining his or her relationship with another person, but it is the response of the latter (and the new response of the former, and so on) that determines the form the relationship will take at each moment. One may therefore state that it is not possible to determine a relationship *unilaterally*. Conversely, relational control is best understood as a *constriction*. In other words, all messages within an interpersonal context somehow constrain or limit the communication options of the other speakers. A message given to A (who we should remember proposes a certain definition of the relationship) "obliges" B to position himself or herself with respect to A (to accept that definition or to propose another) and may limit the options of B, who in turn will impose a certain constriction on the next message of A, and so on successively. The implication underlying this form of control is that different maneuvers of control may be equally controlling and that a "one-down" message may be as controlling—or even more so—as a "one-up" message.
3. This study showed that on comparing prepost measures, clients who at termination of treatment were rated therapeutic successes showed significant increases in their specific self-efficacy and specific internal locus of control. Conversely, clients in the "no change" group did not show any changes in these variables.

References

Abramowitz, C. V., Abramowitz, S. I., Roback, H. B., & Jackson, C. (1974). Differential effectiveness of directive and nondirective group therapies as a function of client internal-external control. *Journal of Consulting and Clinical Psychology, 42,* 849–853.

Altuna, A., Beyebach, M., Piqueras, R., & Rodríguez-Arias, J. L. (1988). La relación terapéutica en primera entrevista de terapia sistémica: Análisis por fases [Therapeutic relationship in first session of systemic therapy: Phase analysis]. In M. Beyebach and J. L. Rodríguez-Arias (Eds.), *Terapia Familiar: Lecturas-I* [Family Therapy Readings, I] (pp. 97–116) Salamanca, Spain: Kadmos.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders, third edition.* Washington, DC: Author.

Anderson, S. A., Atilano, R. B., Bergen, L. P., Russell, C. S., & Jurich, A. P. (1985). Dropping out of marriage and family therapy: Intervention strategies and spouses' perceptions. *The American Journal of Family Therapy, 13,* 39–54.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin, 82,* 738–783.

Bailín, M. C. (1995). *Estudio sobre el cumplimiento de prescripciones en un modelo de terapia sistémica* [Prescription compliance in systemic therapy]. Unpublished doctoral dissertation. Salamanca, Spain: Universidad Pontificia.

Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology, 25,* 729–735.

Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution-focused approach.* New York: W. W. Norton.

Beyebach, M. (1993). *Relación terapéutica y abandono en terapia sistémica breve* [Therapeutic relationship and dropout in brief systemic therapy]. Unpublished doctoral dissertation, Universidad Pontificia, Salamanca, Spain.

Beyebach, M. (1995). Avances en terapia breve centrada en las solucione [Advances in solution-focused therapy]. In J. Navarro Góngora & M. Beyebach (Eds.), *Avances en terapia familiar sistémica* (pp. 157–194) Barcelona, Spain: Paidós.

Beyebach, M., de la Cueva, F., Ramos, M., & Rodríguez-Arias, J. L. (1990, June). *Relational communication control in first interviews of systemic therapy.* Paper presented at the International Communication Association Annual Meeting, Dublin, Ireland.

Beyebach, M., Macías Sánchez, P., Abad López, A. M., Arribas de Migues, F. J., Díez Méndez, A. B., Pérez Mateos, I., & Rodríguez Morejón, A. (1994, November). *El impacto de la supervisión en vivo sobre la conducta de los terapeutas en formación* [The effect of live supervision on the in-session behavior of trainees]. Paper presented at the XV National Conference on Family Therapy, Vitoria (Spain).

Bischoff, R. J., & Sprenkle, D. H. (1993). Dropping out of marriage and family therapy: A critical review of research. *Family Process, 32,* 353–375.

Breteler, R., Mertens, N., & Rombouts, R. (1990). Motivation to change smoking behavior: Determinants in the contemplation stage. In L. R. Schmidt, P. Schwenkmezger, J. Weinman, & S. Maes (Eds.), *Theoretical and applied aspects of health psychology.* London: Harwood Academic Publisher.

Buddeberg, C. (1987). Behandlungsabbruch: Erfolglose Kurztherapie? [Interruption of treatment: Unsuccessful brief therapy?] *Praxis der Psychotherapie und Psychosomatik, 32,* 221–228.

Cervone, D. (1991). The two disciplines of personality psychology. *Psychological Science, 2,* 371–377.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurements, 20,* 37–46.

Craig, A., & Andrews, G. (1985). The prediction and prevention of relapse in stuttering: The value of self-control techniques and locus of control measures. *Behavior Modification, 9,* 427–442.

De la Cueva, F. (1993). *Análisis de primeras entrevistas de MRI mediante el Sistema de Codificiación del Control de la Comunicación Relacional* [Analysis of first interviews of MRI therapy with the Relational Control Communication Coding System]. Unpublished doctoral dissertation, Universidad Pontificia, Salamanca, Spain.

De Shazer, S. (1982). *Patterns of brief family therapy.* New York: W. W. Norton.

De Shazer, S. (1985). *Keys to solution in brief therapy.* New York: W. W. Norton.

De Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: W. W. Norton.

De Shazer, S. (1991). *Putting difference to work.* New York: W. W. Norton.

De Shazer, S. (1994). *Words were originally magic.* New York: W. W. Norton.

Dubrin, J. R., & Zastowny, T. R. (1988). Predicting early attrition from psychotherapy: An analysis of a large private-practice cohort. *Psychotherapy: Theory, Research and Practice, 25,* 393–408.

Duehn, W. D., & Proctor, E. K. (1977). Initial clinical interaction and premature discontinuance in treatment. *American Journal of Orthopsychiatry, 47,* 284–290.

Ericson, P. M., & Rogers, L. E. (1973). New procedures for analyzing relational communication. *Family Process, 12,* 245–267.

Fiester, A. R., & Rudestam, K. E. (1975). A multivariate analysis of the early dropout process. *Journal of Consulting and Clinical Psychology, 43,* 528–535.

Fisch, R., Weakland, J. H., & Segal L. (1982). *The tactics of change: Doing therapy briefly.* San Francisco: Jossey-Bass.

Fontecilla, G., Ramos, M. M., & Rodríguez-Arias, J. L. (1993, November). *Evaluación de resultados en terapia familiar breve* [Outcome research in brief family therapy]. Paper presented at the XIV National Conference on Family Therapy, Santiago de Compostela, Spain.

Foon, A. E. (1987). Review: Locus of control as a predictor of outcome of psychotherapy. *British Journal of Medical Psychology, 60,* 99–107.

Foon, A. E. (1989). Mediators of clinical judgment: An exploration of the effect of therapists' locus of control on clinical expectations. *Genetic, Social and General Psychology Monographs, 115,* 243–266.

Frank, J. D. (1985). Therapeutic components shared by all psychotherapies. In M. J. Mahoney & A. Freeman (Eds.), *Cognition and psychotherapy.* New York: Plenum.

Friedlander, M. L., & Heatherington, L. (1989). Analyzing relational control in family therapy interviews. *Journal of Counseling Psychology, 36,* 139–148.

Friedlander, M. L., Wildman, J., & Heatherington, L. (1991). Interpersonal control in structural and Milan systemic family therapy. *Journal of Marital and Family Therapy, 17,* 395–408.

Garfield, S. L. (1986). Research on client variables in psychotherapy. In S. L. Garfield and A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.). New York: Wiley.

Garland, H. (1984). Relation of effort-performance expectancy to performance in goal-setting experiments. *Journal of Applied Psychology, 69,* 79–84.

Gaul, R., Simon, L., Friedlander, M. L., Cutler, C., and Heatherington, L. (1991). Correspondence of family therapists' perceptions with F-RCCCS coding rules for triadic interactions. *Journal of Marital and Family Therapy, 17,* 379–393.

Gergen, K. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40,* 266–275.

Gilligan, S., & Price, R. (Eds.). (1993). *Therapeutic conversations.* New York: W. W. Norton.

Gingerich, W. J., de Shazer, S., & Weiner-Davis, M. (1987). Constructing change: a research view of interviewing. In E. Lipchik (Ed.), *Interviewing.* Rockville, MD: Aspen.

Gottman, J. M., & Roy, A. K. (1990). *Sequential analysis: A guide for behavioral researchers.* New York: Cambridge University Press.

Greenberg, L. S., & Pinsof, W. M. (1986). Process research: current trends and future perspectives. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process. A research handbook.* New York: Guilford.

Gunzburger, D., Henggeler, S., & Watson, S. (1985). Factors related to premature termination of counseling relationship. *Journal of College Student Personnel, 26,* 456–460.

Hardin, S. I., Subich, L. M., & Holvey, J. M. (1988). Expectations for counseling in relation to premature termination. *Journal of Counseling Psychology, 35,* 37–40.

Heatherington, L. (1988). Coding relational communication control in counseling: Criterion validity. *Journal of Counseling Psychology, 35,* 41–46.

Heatherington, L,. & Allen, G. J. (1984). Sex and relational communication patterns in counseling. *Journal of Counseling Psychology, 31,* 287–294.

Heatherington, L., & Friedlander, M. L. (1987). *Family relational communication control coding system coding manual.* Unpublished manuscript. Psychology Department, Williams College, Williamstown.

Hill, C. E. (1985). *Manual for the Hill counselor verbal response category system.* Unpublished manuscript.

Hoffman, L. (1990). Constructing realities: An art of lenses. *Family Process, 29,* 1–12

Kiesler, D. J. (1973). *The process of psychotherapy.* Chicago: Aldine.

Lichtenberg, J. W., & Barké, K. H. (1981). Investigation of transactional communication relationship patterns in counseling. *Journal of Counseling Psychology, 28,* 471–480.

Mark, R. A. (1971). Coding communication at the relationship level. *Journal of Communication, 21,* 221–232.

Markus, H., & Cross, S. (1990). The interpersonal self. In L. A. Pervin (Ed.), *Handbook of personality theory and research.* New York: Guilford.

Martín Tabernero, M. F., Fernández Pulido, R., & Seisdedos Benito, A. (1985). *Estadística inferencial: Manual de prácticas para las ciencias de la conducta* [Inferential statistics: Manual for the behavioral sciences]. Salamanca, Spain: Universidad Pontificia de Salamanca.

Mennicke, S. A., Lent, R. W., & Burgoyne, K. L. (1988). Premature termination from university counseling centers: A review. *Journal of Counseling and Development, 66,* 458–465.

Millar, F. E., Rogers, L. E., & Beavin, J. (1984). Identifying patterns of verbal conflict in interpersonal dynamics. *The Western Journal of Speech Communication, 48,* 231–246.

Mischel, W. (1968). *Personality assessment.* New York: Wiley.

Mischel, W. (1973). Toward a cognitive social learning reconceptualization of personality. *Psychological Review, 80,* 252–283.

O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions.* New York: W. W. Norton.

Palenzuela, D. L. (1988a). *Control personal: Un enfoque integrativo-multidimensional* [Personal control: An integrative-multidimensional approach]. Unpublished manuscript.

Palenzuela, D. L. (1988b). Refining the theory and measurement of expectancy of internal versus external control of reinforcement. *Personality and Individual Differences, 9,* 607–629.

Palenzuela, D. L. (1990, November). *Midiendo las expectativas generalizadas de control: primeros datos* [Measuring the generalized expectancies of control: preliminary data]. Paper presented at the VIII Congreso Nacional de Psicología, Barcelona, Spain.

Palenzuela, D. L. (1993). Personal control: an integrative-multidimensional approach. In D. L. Palenzuela & A. M. Barros (Eds.), *Modern trends in personality theory and research* (pp. 87–108). Porto, Spain: APPORT.

Palenzuela, D. L., Almeida, L., Prieto, G., & Barros, A. M. (1992). Estudio transcultural de la escala expectativas de control percibido (ECP) [Transcultural study of the expectancies of perceived control scale]. *Memoria Final de la Acción Integrada entre España y Portugal* (66 B), Universidades de Salamanca-Minho, Salamanca-Braga.

Palenzuela, D. L., & Barros, A. (1993). Modern trends in personality theory research: An introduction. In D. L. Palenzuela & A. M. Barros (Eds.), *Modern trends in personality theory research* (pp. 9–27). Porto, Spain: APPORT.

Palenzuela, D. L., & Rodríguez Morejón, A. (1993). Cognitivismo y personalidad: un análisis histórico-epistemológico [Cognitivism and personality: A historical-epistomological analysis]. *Revista de Historia de la Psicología, 14,* 417–426.

Pekarik, G. (1983). Follow-up adjustment of outpatient dropouts. *American Journal of Orthopsychiatry, 53,* 501–511.

Pekarik, G. (1985a). Coping with dropouts. *Professional Psychology: Research and Practice, 16,* 114–123.

Pekarik, G. (1985b). The effects of employing different termination classification criteria in dropout research. *Psychotherapy, 22,* 86–91.

Pérez Grande, M. D. (1991). Evaluación de resultados en terapia sistémica breve [Outcome research in brief systemic therapy]. *Cuadernos de Terapia Familiar, 18,* 93–110.

Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research, 12,* 557–575.

Presley, J. H. (1987). The clinical dropout: A view from the client's perspective. *Social Casework: The Journal of Contemporary Social Work, 23,* 603–608.

Rodríguez Morejón, A. (1994). *Un modelo de agencia humana para analizar el cambio en psicoterapia: Las expectativas de control en terapia sistémica breve* [A human agency model to analyse the change in psychotherapy: The expectancies of control in brief sistemic therapy]. Unpublished dissertation, Universidad Pontificia de Salamanca.

Rodríguez Morejón, A., & Beyebach, M. (1994). Terapia sistémica breve: Trabajando con los recursos de las personas [Brief systemic therapy: Working with resources]. In M. Garrido & J. García (Eds.), *Psicoterapia. Modelos contemporáneos y aplicaciones* (pp. 241–289). Valencia, Spain: Promolibro.

Rodríguez Morejón, A., Palenzuela, D. L., & Beyebach, M. (in press). Un modelo cognitivo para analizar el cambio intrapersonal en terapia familiar sistémica [A cognitive model for the analysis of interpersonal change in systemic family therapy]. In A. Espina (Ed.), *Terapia familiar: clínica e investigación.* Valencia, Spain: Promolibro.

Rodríguez Morejón, A., Palenzuela, D. L., & Rodríguez-Arias, J. L. (in press) La relación de colaboración en terapia sistemica breve: un analisis desde las expectativas de control [The collaborative relationship in brief systems therapy: A control expectancies analysis]. In A. Espina (Ed.), *Terapia familiar: clínica e investigación.* Valencia: Promolibro.

Rogers, L. E. (1979). *Relational communication control coding manual.* Unpublished manuscript.

Rogers, L. E., & Bagarozzi, D. A. (1983). An overview of relational communication and implications for therapy. In D. A. Bagarozzi, M. Jurich, & R. W. Jackson (Eds.), *Marital and Family Therapy* (pp. 48–78). New York: Human Sciences Press.

Rogers, L. E., & Farace, R. V. (1975). Analysis of relational communication in dyads: New measurement procedures. *Human Communication Research, 1,* 222–239.

Rogers, L. E., Millar, F. E., & Bavelas, J. B. (1985). Methods for analyzing marital conflict discourse: Implications of a systems approach. *Family Process, 24,* 175–187

Rogers-Millar, L. E., and Millar, F. E. (1979). Domineeringness and dominance: A transactional view. *Human communication research, 5,* 238–246.

Rotter, J. B. (1954). *Social learning and clinical psychology.* Englewood Cliffs, NJ: Prentice Hall.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs, 80*(1), 609.

Rotter, J. B. (1990). Internal versus external control of reinforcement: A case history of a variable. *American Psychologist, 45,* 489–493.

Scharamski, T. G., Beutler, L. E., Lauver, P. J., Arizmendi, T. A., & Shanfield, S. B. (1984). Factors that contribute to post-therapy persistence of theapeutic change. *Journal of Clinical Psychology, 40,* 78–85.

Segal, L. (1986). *The dream of reality.* New York: W. W. Norton.

Sherman, T. R, & Anderson, C.A. (1987). Decreasing premature termination from psychotherapy. *Journal of Social and Clinical Psychology, 5,* 298–312.

Sluzki, C. (1983). Process, structure, and world views: Toward an integrated view of systemic models in family therapy. *Family Process, 22,* 369–376.

Sluzki, C. (1992). Transformations: a blueprint for narrative changes in therapy. *Family Process, 31,* 217–230.

Sluzki, C.E., & Beavin, J. (1965). Symmetry and complementarity: An operational definition and typology of dyads. In P. Watzlawick & J. H. Weakland (Eds.), *The interactional view.* New York: W. W. Norton.

Stahler, G. J., & Eisenman, R. (1987). Psychotherapy dropouts: Do they have poor psychological adjustment? *Bulletin of the Psychonomic Society, 25,* 198–200.

Trepka, C. (1986). Attrition from an out-patient psychology clinic. *British Journal of Medical Psychology, 59,* 181–186.

Watzlawick, P. (1984). *The invented reality.* New York: W. W. Norton.

Watzlawick, P., Beavin, J., & Jackson, D. D. (1967). *The pragmatics of human communication.* New York: W. W. Norton.

Weisz, J. R. (1986). Contingency and control beliefs as predictors of psychotherapy outcomes among children and adolescents. *Journal of Consulting and Clinical Psychology, 54,* 789–795.

White, M. (1995). *Re-authoring lives: Interviews and essays.* Adelaide, Australia: Dulwich Centre Publications.

White, M., & Epston, E. (1989). *Narrative means to therapeutic ends.* Adelaide, Australia: Dulwich Centre Publications.

Zeig, J. K., & Gilligan, S. G. (Eds.). (1990). *Brief therapy: Myths, methods, and metaphors.* New York: Brunner/Mazer.