Journal of Systemic Therapies, Vol. 23, No. 2, 2004

BETWEEN-SESSION CHANGE IN SOLUTION-FOCUSED THERAPY: A REPLICATION

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This paper presents a replication of the Reuterlov, Lofgren, Nordstrom, Ternstrom, and Miller study (2000) on the stability of clients' descriptions of improvement during solution-focused therapy. Our replication confirmed that the great majority of clients who report improvements at the outset of a session tend to increase their answer to the scaling question at the end of the interview. We also confirmed Reuterlov et al.'s finding that when clients begin the session without reporting improvements, they tend to not see improvements at the end of it, in spite of their therapists' best efforts to "deconstruct" their initial description. However, our findings are less clear-cut than those of the Swedish team, and suggest that in some occasions (37.5% in our study, as opposed to 13% in the original paper) deconstruction may pay off as a therapeutic strategy, helping clients who initially do not describe any improvements to see some at the end of the session. Therefore, we consider it premature to dismiss deconstruction as a useless therapeutic strategy, and suggest that more studies be done on the conditions under which it is most helpful.

In their 2000 article, Scott Muller and his Swedish colleagues (Reuterlov, Lofgren, Nordstrom, Ternstrom, & Miller, 2000) studied the process of change in solution-focused therapy. They analyzed the opening and final phases of 93 sessions of solution-focused therapy to find out whether there was a change from initial client statements about improvements to clients' answers to the scaling question asked at the end of the session. More specifically, they distinguished between clients who answered the opening question ("What is better?") describing improvements, and those who did not describe anything as "better." Then, they looked at their answers to the scaling question at the end of the session. If the number was higher

This article is based on a paper presented at the European Brief Therapy Association Meeting held in Dublin, Ireland, September 2001. The authors wish to acknowledge the useful suggestions of two anonymous reviewers, as well as the valuable help of the editors. Address correspondence to: Mark Beyebach, Universidad Pontificia de Salamanca, Salamanca, Spain. E-mail: mark.beyebach@upsa.es.

than that given in the previous session, the case was categorized as "improved" by the end of that session; if not, it was seen as "not improved." After that, the authors performed a simple but elegant analysis, recounting how many of the clients who initially did and did not report improvements did or did not go up on the scaling question by the end of the session. They found out that only 13% of the clients who initially did not report improvements improved by the end of the session. The other 87% confirmed their initial negative report by staying the same on the scale, or giving a lower number.

Reuterlov et al. (2000) believed their data supports the idea that if no improvements are evident at the beginning of the session, it might be preferable for the therapist to take that report at face value, accept that there is not anything "better," and change to a different, non-solution-focused approach to bring about some changes. This contradicts the classic solution-focused tenet that initial negative reports should be "deconstructed" (de Shazer, 1988; de Shazer & Berg, 1990; O'Hanlon & Weiner-Davis, 1989) so as to generate small differences that might eventually change the picture and help clients see some improvements. In Reuterlov et al.'s view, this emphasis on deconstruction might be counterproductive:

> The present research suggests that clients' reports of a lack of progress at the outset of the visit be taken seriously and not be subjected to any therapeutic maneuver aimed at "re-framing," "re-storying," or "re-constructing" the time between sessions as a success. Specifically, reports of lack of change likely signal the need to alter treatment to maintain the relationship and increase the likelihood of success (Reuterlov et al., 2000, p.114).

If replicated, the outcome of this study might have some profound implications for the theory and practice of solution-focused therapy. They relate to a dilemma solution-focused therapists often find themselves in: that of deconstructing (trying to find small changes in spite of the initial negative report, and therefore staying "solution-focused") *versus* "doing something different" (and therefore probably moving out of the "solution-focused approach") when clients start saying that nothing is "better." They also relate to concerns about whether and when to integrate non-solution-focused practices in a solution-focused therapy (Beyebach & Rodríguez Morejón, 1997; Beyebach & Rodríguez Morejón, 1999) and, more broadly, to the question of how and when to integrate different techniques in a given therapy (Pinsof, 1995). If replicated in more studies, the Reuterlov et al. (2000) finding that deconstruction does not help clients to change their view on improvements, might provide an empirical argument in favor of a more eclectic, flexible practice. "No-improvement" reports should then lead the therapist to look for different, potentially more useful approaches, instead of insisting on the solution-focused deconstruction strategy.

In this paper we present a replication of the Reuterlov et al. (2000) research. In our study, we analyzed a sample of comparable size, using a (presumably) identical solution-focused approach, and employing the same methodology and design.

We will briefly present the methodological features of our replication study, show the results, and discuss their meaning and implications.

METHOD

Sample

The sample of our study consists of 96 therapy sessions from 16 cases seen between December 1998 and June 2001 at the family therapy center of the Universidad Pontificia de Salamanca (Spain). The 16 cases were selected from all those that were seen in that period, excluding those where only one or two sessions had been held, and those where not all sessions had been videotaped.

The family therapy center of the Universidad Pontificia, where a postgraduate program in solution-focused brief therapy is run, offers free treatment, with clients being referred by former clients, doctors, psychologists, psychiatrists, and social workers. In 8 cases, the sessions were conducted by trainers and in the other 8 cases, by trainees. All of them were supervised by the rest of the training group. The two trainers were psychologists with doctorate degrees and had an average clinical experience of 9 years; the trainees were degreed psychologists and had participated for at least 1 year in an intensive solution-focused therapy training program.

The clients in this sample sought help for a variety of reasons, including eating disorders, anxiety, depression, marital discord, and behavioral problems of children. In 11 of the 16 cases the problem was presented by an adult, in three by a child, and in two cases by an adolescent. In eleven cases, the majority of the sessions (more than 50%), were conjoint. In the majority of the remaining five cases only one client participated in sessions. The average number of sessions per case was six; all cases had at least three sessions, and two of them had more than ten.

Treatment Approach

The treatment approach used was solution-focused therapy (SFT) (de Shazer, 1988, 1991, 1994; de Shazer et al., 1986; O´Hanlon & Weiner-Davis, 1989). Using de Shazer and Berg´s criteria for SFT (de Shazer & Berg, 1997), the Miracle Question was asked in 100% of the first sessions, scaling questions were asked in 87.5% of the sessions, and in 100% of the sessions there was an intersession break after which compliments and eventually tasks were transmitted. In our way of working, and according to SFT, every session after the first one began by asking "What is better?" The scaling question is asked at the end of each session: "On a scale from 1 to 10, where 1 stands for when the problems that brought you in were at their worst, and 10 means that they are solved, where would you put yourself today?"

Procedure and Analysis

An independent researcher (a graduate psychology student, blind to the purpose of the study) reviewed all 96 sessions, transcribing the exact wording of the opening phrases and the first answers of the clients. The transcriptions were independently coded by the two authors, after a brief e-mail exchange with Scott Miller to make sure that the coding was done in the same way as in the original Reuterlov et al. (2000) study. The answers were coded as "improvement" if the client reported that something was better since the last session, and as "no improvement" if the client did not report improvements, or said that things had been worse. When more than one client participated in a session, each client was coded separately. The degree of agreement in the coding was 93%. The answers that received a different coding by the two coders were excluded from the analysis.

The independent researcher also reviewed the final part of every session and wrote down each client's answer to the scaling question. After that, she compared the answers with the figures obtained in the previous session, and classified them as "better," "the same," and "worse," depending on whether they exceeded or not the figures of the previous session. If there was more than one client present, the comparison was always done with the answer of that same person in the previous session.

In order to compare the Swedish (Reuterlov et al., 2000) and the Salamanca samples, we performed two chi-square analyses. The first comparison involved the "improvement" cases of both samples, and required us to collapse the "same on scale" and "worse on scale" categories into one (because the original study had no clients that rated the scaling question "worse" at the end of the session), yielding a 2×2 contingency table. In the second comparison we included the "nonimprovement" cases of both samples, in a 2×3 contingency table.

RESULTS

Some data were missing: not all clients participated in all sessions; some did not answer the opening and/or scaling question; and in some sessions the opening or closing dialogues were not properly recorded. Therefore, the final sample includes 106 answers to the opening "What's better?" question, and 93 answers to the scaling question.

Overall, there were 59 statements of improvements (56% of the initial statements), and 47 of no improvement (44%) at the beginning of the session. On the scaling question, improvements were registered on 59 occasions (63%), on 18 (20%) the figure was the same as in the previous session, and in 16 occasions (17%) the figure was lower.

Comparing both sets of data (Table 1), of the 53 clients who started reporting some improvements at the beginning of a session and for whom we had data from

Table 1. Comparaison of the Swedish and Salamanca Samples

	END OF SESSION RATING		
	Better	Same	Worse
INITIAL RATING OF PROGRESS			
Initial Improvement			
Swedish Clients	80% (n = 79)	20% (n = 19)	0
Salamanca Clients	83% (n = 44)	15% (n = 8)	2% (n = 1)
No initial Improvement			
Swedish Clients	13% (n = 4)	42% (n = 13)	45% (n = 14)
Salamanca Clients	37.5% (n =15)	37.5% (n = 15)	25% (n = 10)

"Initial improvement" and "No initial improvement" refer to the number of positive or negative answers to the question "What's better?", asked at the opening of each session. "Better," "same," and "worse" refer to the answer the client gives to the scaling question at the end of the session, as compared to the answer given in the previous session.

the scales, 44 (83%) did indeed go up on the scale (in relation to the previous session) by the end of the interview. Only 8 (15%) of those initially reporting improvements gave the same number in answering the scaling question, and only one (2%) gave a lower rating. On the 40 occasions that a client started the session by not reporting any improvements, 10 (25%) did stay the same on the scaling question and 15 (37.5%) gave an inferior number, but another 15 (37.5%) went up on the scale as compared to the previous session.

Comparing our data with those of the Swedish study, we found no significant difference between the "improved" cases of both samples ($\chi^2 = .021$; $df = 2$; $p = .89$). However, there was a significant difference in the distribution of the "nonimprovement" cases in both studies ($\chi^2 = 6.136$; $df = 3$; $p = .0465$).

DISCUSSION

Overall, our data are in accordance with the Reuterlov et al. (2000) findings and show that initial descriptions of improvement *versus* non-improvement tend to be stable during solution-focused therapy sessions. On the positive side, we found, as Scott Muller and his colleagues did, that clients who start off reporting improvements are very likely to go up on the scale by the end of the session, thereby confirming their initial description that things are "better." This was the case with 83% of the clients in our study who started saying that things had gotten better, and in 80% of the clients' in Reuterlov et al.'s (2000) study. Initial descriptions of improvement seem, therefore, to be quite solid. On the negative side, we found—as the Swedish team did—that when no improvements are reported at the beginning of the session, clients tend also not to report them at the end of the interview.

In other words, in spite of solution-focused therapists' efforts to deconstruct initial negative descriptions, on most occasions they are not able to move their clients' description toward a report of improvement by the end of the session (or at least not as reflected by the answers to the scaling question). This was the case with 62.5% of the clients in our study who did not report improvements at the opening of the session, and in 87% of the clients in Reuterlov et al.'s study. Therefore, initial negative descriptions also seem quite stable.

In our study, however, the findings where not as clear-cut as in the research by the Swedish team: more than one-third of our clients who at the onset of the session described no improvements, did go up on the scale by the end of the session. Our figure (37.5%) is almost triple that of the Reuterlov et al. study (13%), and indeed the chi-square analysis of the distribution showed a statistically significant difference between the two "non-improved" samples. Therefore, we did not replicate this result of the Swedish study.

In our view, this difference between the two studies leaves an open door to uncertainty. If deconstruction were only successful in one occasion out of every eight (the 13% figure in Reuterlow et al., 2000), one would feel tempted to agree that deconstruction is not a useful maneuver in the face of initial negative reports. However, with almost 4 out of every 10 initially "negative" clients changing their description over the course of the session (our 37.5% finding), one might see the role of therapeutic deconstruction in a more positive light. Maybe, instead of dismissing it as a useless procedure, it becomes worthwhile to study more carefully under what circumstances it does work, and under what circumstances it does not. What is different in that 37.5% of the sessions where deconstruction apparently did reach it's goal? How could solution-focused therapists do more of it?

In interpreting our findings, however, it should be taken into account that the differences between our results and those of the Reuterlow et al. (2000) study may be due to a variety of reasons. On the one hand, the samples of clients are quite different, and so are the therapists involved (experienced therapists in the Swedish study, a mixture of experienced therapists and trainees in our study). It also remains to be empirically documented that the treatments in both studies were indeed comparable. In fact, in our center the approach is basically solution-focused, but sometimes techniques from the related model, the Mental Research Institute brief therapy approach (Watzlawick, Weakland and Fisch, 1974; Fisch, Weakland, & Segal, 1982), and narrative approaches (White & Epston, 1989), are borrowed. Although in our practice deconstruction always takes priority over the use of non-solution-focused techniques, it cannot be ruled out that our higher percentage of improvement by the end of the session after an initial nonimprovement report is precisely an effect of our sometimes changing toward a less solution-focused track.

The different ratings of initial improvement in the studies (56% in ours, 76% in the Swedish study) might also be due to a number of factors such as a higher average number of sessions per case in our sample or some undetected differences in treatments or samples. For example, a difference may exist between

the treatments in the two studies, related to the exact wording of the opening "What is better?" question. In spite of clear indications to ask the question in a presuppositional way, a close examination of the transcripts of our cases revealed that on a presupossitional form ("How are things going?" "Is anything better?"). This led us to code all opening questions as presuppositional or non-presuppositional, and reanalyze the data. Interestingly enough, we found no statistical differences between the improvement reports following the two types of openings. After presuppositional questions, 51% of the clients gave an "improvement" answer and after a non-presuppositional question, 64% did!

Cultural differences between Swedish and Spanish citizens may also have had an impact on whether and how improvements were reported. Although both Sweden and Spain are european countries, their cultural heritage differs in many ways, probably including the way psychotherapy is understood. In the Spanish context, it is not unlikely for clients to see therapy mainly as the place where problems are discussed and complaints are voiced. Therefore we might speculate that, in spite of therapists' efforts to construct a different kind of conversation, our clients prefer to start stating what is not improving, even if they are seeing overall progress; once they have voiced their complaints, they would be prepared to move on and discuss improvements. Should our description be accurate, one might wonder if Swedish clients follow the same pattern, and if there are further differences in the way they construct and report (the same) improvements.

In our view, both our replication and the original study have at least two major methodological shortcomings. On the one hand, in both projects it is assumed that the answers to the "What is better?" question and to the scaling question are comparable. This is in no way guaranteed. It could well be that we would find a different picture if we asked "What is better?" both at the beginning and at the end of the session (or if we asked the same scaling question at the beginning and at the end of the session). It is also questionable that the answers to the scaling question from one session to the other are truly comparable.

On the other hand, we are also assuming that, when the initial description changes, it might be due to the process of deconstruction. There are a number of objections to this inference. First, in none of the two studies has the deconstruction process been documented. It is not clear if it really was undertaken in all sessions, nor in what way it was done by the different therapists. Second, even if deconstruction was properly performed on all occasions, the design of both studies does not allow to make any claims about it's causal role in the change of the clients' narrative.

One way to overcome this limitation would be to perform a more fine-grained process-outcome-study of what actually happened during the therapeutic sessions in our sample. As all sessions in our study were videotaped, we intend to identify those sessions where client descriptions changed more clearly from the beginning to the end of the interview, in order to develop some preliminary hypotheses of what accounts for the change. It would also be interesting to see if the outcome of the deconstruction process holds up until the next session; for example, to ana-

lyze whether a client who starts a session complaining about no improvements, and who at the end of the sessions has changed toward describing the situation as better than initially though, does "keep" these improvements until the next session. Another option, which we are also currently researching, is to make a direct, controlled comparison between the two strategies: "deconstruction" versus "changing gears." Although this project is a complex one, we hope that it will produce some data that might assist solution-focused therapists in their decision-making process during therapy.

CONCLUSIONS

Our study replicates the Reuterlov et al. finding (2000) that clients' initial descriptions of improvement tend to be confirmed by the end-of session ratings. This is coherent with the solution-focused approach of amplifying the positive changes that clients report at the beginning of the session and of constructing more resources and exceptions during the conversation (de Shazer, 1991, 1994).

However, in those cases where clients did not describe improvements at the beginning of the session, our findings differ from those by Reuterlov et al. Whereas in the Swedish study almost all these clients did not see improvements by the end of the session, in our study a substantial proportion of the initially negative clients moved to see their situation as "better" by the end of the therapeutic conversation. Therefore, one possible interpretation of our data could be that clinicians do have more options in the face of initial reports of lack of progress than to immediately shift gears and alter the treatment being offered, as Reuterlov et al. suggested. No-change reports should of course be taken seriously and be accepted (de Shazer, 2004), but then it might be useful for therapists to try and help clients to see some differences, before they decide to change their direction completely. There are a number of possibilities to generate some useful differences in the description of the situation: looking for smaller changes or for changes in different areas; asking from the perspective of other people or in relation to different points in time; simply waiting or asking how the clients have coped; or wondering why the situation is not worse and so on. If any of these deconstruction strategies lead to the description of some relevant improvements, they can be expanded and built upon. If not, it might be wise to use that feedback (Miller, Duncan & Hubble, 2004) and start a different approach, as the Swedish study suggested (Reuterlov et al., 2000).

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