Journal of Systemic Therapies, Vol. 33, No. 1, 2014, pp. 48–61

SOLUTION-FOCUSED RESPONSES TO "NO IMPROVEMENT": A QUALITATIVE ANALYSIS OF THE DECONSTRUCTION PROCESS

ANDRÉS SÁNCHEZ-PRADA
Pontifical University of Salamanca, Spain
MARK BEYEBACH
Partners for Collaborative Change, Miranda de Azán, Spain

When a client reports no improvement since the previous session, one response for the therapist can be to deconstruct this description and seek improvements, however small. A qualitative, discovery-oriented study examined the process of deconstruction in eight solution-focused brief therapy sessions where clients had initially reported no improvement. The findings suggested that the deconstruction of initial reports of no improvement is a complex process in which therapists do not follow a single path but respond in a flexible way to their clients' discourse: They may move directly into deconstruction, elaboration, and consolidation or may begin indirectly by first connecting with the negative report and preparing for deconstruction. Overall, maintaining positive (versus negative) topics in the conversations is important, but other therapeutic topics can be helpful at some points. It may also be useful to move systematically along a specificity-generality continuum, whether from specific episodes to general evaluations or the reverse.

Since the late 1980s, many theorists and practitioners in the field of family therapy have embraced a social constructionist perspective, which includes the proposal that therapeutic change occurs through language during the process of therapeutic conversations (e.g., Anderson & Goolishian, 1988; Sluzki, 1992; Tomm, 1987a, b).

This study was completed as part of the first author's doctoral dissertation at the Pontifical University of Salamanca. We gratefully acknowledge the patient editing of Janet Bavelas, as well as the suggestions of the other contributors to this special section.

This article, as all of those included in this special section, focuses on the relevance of research for practitioners. Therefore, many specialized research details were omitted because of space limitations. Complete methodological information is available from the first author.

Address correspondence to Andrés Sánchez-Prada, Department of Psychology, Pontifical University of Salamanca, Compañía 5, 37002 Salamanca, Spain. E-mail: asanchezpr@upsa.es

In this perspective, solution-focused brief therapy (SFBT) can be described as a linguistic process in which therapist and clients co-construct new realities in order to dissolve what clients initially perceive as their problems (De Shazer, 1994). That is, they co-construct a new conversational context that focuses on the details of solutions rather than on the details of problems.

From the first session, SFBT therapists focus their conversations with clients on goals, resources, and exceptions to the problem. Indeed, their preferred opening of second and subsequent sessions is to ask "What is better?" When clients describe some improvement, the therapist follows this theme, trying to get a detailed description of the improvements and to co-construct them as something clients have brought about deliberately (O'Hanlon & Weiner-Davis, 1989). However, sometimes clients answer the initial "What's better?" question by reporting that there is no improvement, that nothing is better, or even that things are worse. In these cases, SFBT therapists try to deconstruct this initial response and to generate a new description that includes some kind of improvement (de Shazer, 1988; de Shazer & Berg, 1992). De Shazer defined this process of deconstruction as "developing doubts about global frames" (de Shazer, p. 101). Several authors have proposed possible questions that might help to deconstruct the initial global frame of no improvement (Berg & Miller, 1992; Beyebach, 2006; de Shazer, 1994):

- Question the initial report: "Are you sure? Is it possible that nothing is better?"
- Ask for smaller changes: "So what is a little bit better?"
- Change the time frame: "So last week was awful; what was better the first week?"
- Change the context: "So things at school have been rocky. What about home?"
- Change the perspective: "What would your wife say is better?"
- Reframe improvements: "How come things are not worse?"
- Use coping questions: "With things being that bad, how are you coping?"
- Use Scaling Questions: "On a scale from 0 to 10, where 10 stands for. . . ."

A DILEMMA NOT COMPLETELY SOLVED

So far, only two studies have examined the effect of the SFBT approach to clients' reports of no improvement. Reuterlov, Lofgren, Nordstrom, Ternstrom, and Miller (2000) analyzed the opening and final phases of 93 SFBT sessions. Their main finding was that only 13% of the clients who had said at the beginning of the session that nothing was better were categorized as improved by the end of the session. The other 87% confirmed their initial negative report by giving the same or even a lower number on the progress-scaling question. Reuterlov et al.'s interpretation was that, when facing a client's initial report of no improvement, it might be more useful for therapists not to persist in following a solution-focused approach, and to change to a different one.

Herrero de Vega and Beyebach's (2004) replication of the Reuterlov et al. (2000) study had somewhat different findings. In a sample of 96 SFBT sessions, they found that 37.5% of the clients who had initially reported no improvement scored higher on the progress scale by the end of the interview. Beyond possible explanations for the difference between the two studies (e.g., samples, cultural context, therapists' experience), their results create some uncertainty. If deconstruction were only successful on one occasion out of every eight (Reuterlov et al.'s 13%), then using the session to deconstruct clients' initial negative reports could be seen as a useless practice. However, when almost four out of every 10 (37.5%) of these initially negative reports changed to progress by the end of the session, then "maybe, instead of dismissing [deconstruction] as a useless procedure, it becomes worthwhile to study more carefully under what circumstances it does work, and under what circumstances it does not" (Herrero de Vega & Beyebach, p. 23). In this sense, before facing the dilemma *to deconstruct or not to deconstruct?* it might be useful to have a closer look at what actually happens in those sessions where deconstruction is attempted, in order to shed light on the conditions that make it helpful.

METHOD

A Qualitative, Discovery-Oriented Design

In line with the increasing demand for studies that come closer to real clinical practice and that narrow the research-practice gap (Trepper, Dolan, McCollum, & Nelson, 2006), this study analyzed a set of therapeutic conversations that took place after clients had reported that their situation had not improved. The method followed a qualitative, discovery-oriented approach, which in recent years has provided interesting insights into different aspects of SFBT practice (e.g., Franklin, 1996; Gale & Newfield, 1992; Lloyd & Dallos, 2006; Nau & Shilts, 2000). The main method used was Greenberg's (1984) Task Analysis method.

The research question guiding this study was what happens in SFBT sessions that start with a report of no improvement followed by a period of deconstruction? In the terminology of Task Analysis (Rhodes & Greenberg, 1994), the initial *rational model* was the starting hypothesis about how the process of deconstruction may unfold. This starting hypothesis was the general description that de Shazer (1988) proposed: a first phase of deconstructing the global frame of no change, followed by a second phase of amplifying and developing the improvements identified in the first phase. Hereafter, this paper presents a detailed analysis of actual therapist-client dialogues, which focused on how solution-focused therapists try to deconstruct, and on how deconstruction works. The ultimate aim of this research was to generate a model of deconstruction that, as a clinical heuristic, might help therapists to successfully shape their conversation with clients in a solution-focused way.

Data

Criteria for Selecting Deconstruction Excerpts. The search for a set of suitable data began by examining videotapes of second or later individual sessions conducted between 1998 and 2006 at the Family Therapy Service of the Pontifical University of Salamanca (part of a postgraduate program in SFBT). The first criteria were those required by Greenberg's (1984) method of Task Analysis, namely, to be considered, a session had to contain an excerpt with three components:

1. An *initial marker*: the client initially reported that there had been no improvement.
2. A *task environment*: the therapist subsequently attempted deconstruction.
3. A *final marker*: the client later gave a final answer to the progress-scaling question.

From an initial pool of 42 potentially eligible individual sessions, eight included excerpts that met these criteria as well as the following additional ones:

4. There had to be a client's numerical answer to the progress-scaling question in the previous session: Four of the excerpts showed improvement after deconstruction and the other four showed no improvement after the attempted deconstruction. That is, in half of the excerpts, the client's final answer to the progress-scaling question was numerically higher than at the end of his or her previous session; in the other half, the client's final answer was not higher than it was at the end of the previous session.
5. Finally, in four of the excerpts (two that improved and two that did not), the therapist was a trainer, and in the other four, the therapist was a trainee.

The mean duration of the eight selected excerpts was 33 minutes, 46 seconds, with no statistically significant difference between those that improved and those that did not improve.

The Therapists. The trainers were PhD psychologists with an average of 12 years clinical experience. The trainees had participated for at least one year in an intensive SFBT training program.

The Clients. The sessions included a variety of individual presenting problems: anxiety, depression, obsessions, grieving, and problems with children. In the four excerpts that improved, the clients were women. In the four excerpts that did not improve, three of the clients were women, and one was a man.

Confirmation of the Criteria. These eight excerpts were transcribed from the initial report of no improvement to the final scaling question. Two independent judges and the first author analyzed the transcripts to confirm that the eight excerpts met all of the criteria. The initial report of no improvement and the final scaling ques-

tion were confirmed with high inter-rater reliability (kappa = 1.0 for both markers). Inter-rater kappa's for identifying deconstruction interventions were .64 to .79. In spite of these low kappas, both judges confirmed that in all eight excerpts, deconstruction was attempted.

Analysis Procedure. Stage I: Developing Relevant Categories

In the first step of analysis, the goal was to create a common vocabulary with which all deconstruction processes could be described. The first author followed an iterative procedure to find a vocabulary that would describe the eight excerpts: He watched the first excerpt and described its key features, then he moved on to the second excerpt to confirm or modify this vocabulary, then he moved on to the third excerpt, and so on. The Atlas-ti 5.0 software (Mühr, 1996) was used to facilitate this analytic process.

This procedure yielded three useful ways to capture the noteworthy differences in how therapists and clients talked during the deconstruction process:

Topic. There were four ways to describe the therapist's or client's topics: (a) A *positive topic* was any description of improvements or accomplishment of therapeutic goals (e.g., "I am more relaxed these days"). (b) A *negative topic* was any description of no improvement or even deterioration (e.g., "I have been more obsessed these days, I just cannot get rid of those thoughts"). (c) An *alternative topic* was related to the therapeutic process, such as future goals, potential resources, or hypothetical scenarios but was not about improvement (e.g., "I wish I could simply turn the thoughts off, to have a way to simply make it stop"). (d) A *tangential topic* was unrelated to the therapy (e.g., "It's pretty cold today").

Generality/Specificity. There were three levels of generality/specificity: (a) An *evaluation* was a general appraisal of an experience (e.g., "Things have been better this week"). (b) An *indicator* described somewhat more specific thoughts, emotions, or behaviors (e.g., "I have been eating more this week"). (c) An *episode* described something that had happened at a specific time and in a specific situation (e.g., "Yesterday I was able to have a full breakfast, I ate with my husband and I even had some bacon and eggs").

Action. The vocabularies for the actions of therapists and the actions of clients were different. The therapist could (a) introduce a *proposition*, which was new information, not previously mentioned by the client, or (b) ask a *question*, which instead requested new information from the client. A client, on the other hand, could (a) make *a contribution* that offered new information, either spontaneously or on request, (b) indicate *acceptance*, explicitly agreeing with something proposed by the therapist, (c) indicate *rejection*, explicitly disagreeing with something proposed by the therapist, or instead (d) express *doubt* about what the therapist had proposed.

Each speech turn was described in terms of its topic, generality/specificity, and action, and a single speech turn could have more than one description. For example:

THERAPIST: "Tell me, on what occasions have you been more relaxed this last week?"
- Some "occasions" being "more relaxed" is a positive topic.
- Being "more relaxed last week" is an indicator (middle level of specificity).
- The therapist's action is a question.

CLIENT: "Never. This has been a terrible week."
- "Never" and "terrible week" are negative topics.
- "Never" refers to the requested indicator. "Terrible" adds a general evaluation.
- Both "never" and "terrible week" are the client's new contributions.

THERAPIST: "How come?"
- The therapist's topic is about the client's negative report.
- The request is very general, asking for an evaluation.
- The action is again a question.

CLIENT: "Anxiety, this week it has skyrocketed. Yesterday I had a fight with my sister and said terrible things to her."
- The topics continue being negative.
- "Anxiety, this week" is an indicator. "A fight" refers to a specific episode.
- The client's actions are again new contributions.

Analysis Procedure. Stage II: Finding a Model of Deconstruction Processes

Having developed a common vocabulary for describing all of the excerpts, the authors then set out to discover the possible differences between those that ended with improvement and those that did not, in order to develop a model of deconstruction that works. Through an intensive qualitative analysis of each excerpt, the emerging hypotheses about what makes the difference in successfully deconstruction processes were constantly compared against the data and refined, along an iterative process that resulted in a progressive development and adjustment of the initial rational model (i.e., the starting hypothesis; Greenberg, 1984; Rhodes & Greenberg, 1994).

RESULTS

Five Phases of Deconstruction

The analyses led to a tentative model of deconstruction that includes up to five conversational phases: *connection*, *preparation*, *deconstruction*, *elaboration*, and *consolidation*. These phases are described below and presented visually in Figure 1.

The phases could occur in either an indirect or a direct approach. The indirect approach began with a *connection phase*, during which the conversation explored

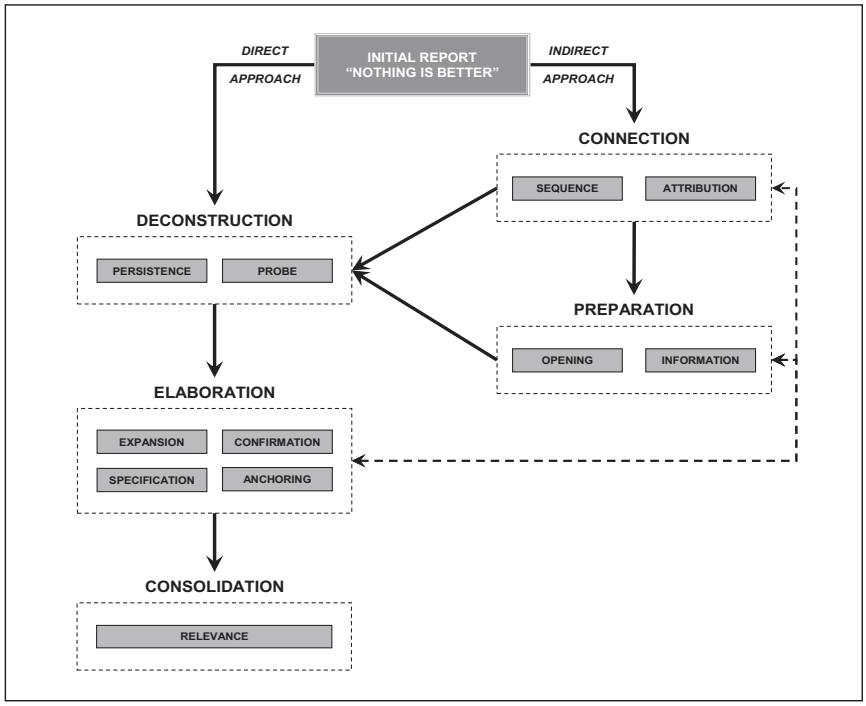

FIGURE 1. A map of deconstruction patterns. Deconstruction sequences developed in two different ways, represented by continuous arrows. The direct approach started with deconstruction and moved on to elaboration and consolidation. The indirect approach began by adding two steps prior to the deconstruction phase: connection and preparation. Broken arrows indicate possible sidesteps along the main sequences (described in the text). The shaded boxes within each phase refer to different ways that the therapists approached their conversation with the client during that phase; e.g., by persisting or probing.

the negative topics that clients had contributed. These topics were often discussed specifically, as episodes (e.g., by exploring the sequence of a specific incident at a specific time). There was also some discussion at the general level of evaluation (e.g., in relation to possible explanatory and causal attributions).

The next phase of the indirect approach was the *preparation phase*, in which the therapist shifted to alternative therapy topics, not directly related to either positive or negative changes. These alternative topics could open the conversation to specific future goals, potential resources, and hypothetical scenarios (i.e., episodes and indicators). They could also be general evaluations (e.g., by informing that things could be better), which created a framework within which differences and improvements in the present might later be noticed. Only then did the conversation move into a deconstruction phase.

The direct approach began with deconstruction immediately, without the two earlier phases. The *deconstruction phase* consisted of conversations that focused on present or past experiences that could be construed as positive. The therapist tried to persist in generating positive indicators and episodes (e.g., specific incidents or feelings related to the therapeutic goals). The therapist might also probe alternative indicators and episodes that, without being clearly positive, were at least different from the initial negative report.

The *elaboration phase* built on the deconstruction phase. The therapist elaborated on the positive and alternative topics by asking for specific details (i.e., indicators and episodes) and also elaborated by expanding these specifics into their personal and interpersonal effects (e.g., "So, in those occasions when you were able to keep anxiety down at home, what was different between you and your sister?"). The therapist also sought explicit confirmation of these improvements from the client and tried to anchor them by highlighting the client's active role in bringing about the changes.

Finally, in the *consolidation phase* the therapist worked more at the evaluation level, relating the now-elaborated positive topics to the client's initial complaint and goals. In other words, the conversations at this stage focused on the therapeutic relevance of the positive topics discussed so far.

Therapists' Perspective: Clinical Decision-Making

Although we have described two patterns in the data, it is important to emphasize that the therapists did not rigidly follow a fixed sequence. From what we observed, the therapists were tracking their client's responses closely. For example, if the client followed the therapist's positive topic in the deconstruction phase (i.e., if the client accepted it or even contributed his or her own positive topic), then the therapist proceeded into the elaboration phase (in the direction of the continuous arrow in Figure 1). If the client rejected or questioned the proposed topic, then the therapist went back one step (e.g., into the preparation phase) before getting on track again.

The step-by-step sequence could also be shortened during the deconstruction phase. If the client accepted or contributed positive topics without hesitation, then therapists would continue elaborating them or even going directly into the consolidation phase. If at any point in the consolidation phase the client showed doubts or rejected the relevance of those topics, the therapist would stop to elaborate them more thoroughly or go back to deconstruction phase in order to get a broader pool of positive (or alternative) topics on which the global improvement could be built in the elaboration and consolidation phases. Even topics tangential to therapy could sometimes be useful for balancing the conversation (Beyebach & Carranza, 1997).

In other words, the interviewing patterns were recursive–the clients responded to their therapists, who then selected aspects of the interview to focus on. The therapists stayed flexible and open to clients' feedback. The broken arrows in Figure 1 represent possible sidesteps in this process: During elaboration, a therapist sometimes went back to acknowledging problems (i.e., to the connection phase)

or to discussing hypothetical alternatives (the preparation phase). Other times, the conversation in the connection or preparation phase generated improvements that could be directly elaborated upon, without any need for deconstruction.

Clients' Perspective: Hypothetical Change Mechanisms

The model of the deconstruction process developed here led to speculation about possible change mechanisms on the clients' part. Over the course of the project, it was observed that the main aspect that differentiated the excerpts that ended with improvement from those that did not was that the client acknowledged the relevance of the positive topics discussed so far. Therefore, it became clear that, from the client's perspective, it was important that the topics remained directly relevant to his or her own goals within the global therapeutic process. A topic's relevance might also be constructed during the therapeutic conversation.

In this sense, movement along the generality/specificity levels of the same topic might play a role in the construction of perceived relevance. Using Pearce and Cronen's (1980) Coordinated Management of Meaning framework, a hierarchical ordering of the three levels of generality/specificity can be proposed, from the evaluation level (highest) to the indicator level (intermediate) and the episode level (lowest). It is then possible to speculate that the evaluation level exerts what Pearce and Cronen called a *downward contextual force*; that is, a general evaluation creates a context for providing more specific indicators and episodes that illustrate the topic of that evaluation. For example, one client started by giving a negative initial report ("not better"; i.e., a general evaluation), illustrated by feelings of loneliness and helplessness (indicators), which in turn led her further downward to talk about specific examples (at the episode level) of being tense and feeling isolated with her group of friends, of not knowing what to do with her kids, and of staying at home crying, "without doing anything good for me."

However, the other direction is also possible: Specific episodes can exert what Pearce and Cronen (1980) described as an *upward implicative force* on indicators. That is, a single specific episode implies that there may be more on the same topic, which in turn implies that something more general may be going on (an indicator), which could lead to an even more general evaluation. For example, the above client discovered one specific, small but positive episode in the deconstruction phase: one day she had "forced" herself to cook for a visitor and had had a good time. She then also recalled that she had gone out once and had a good experience, she had been buying Christmas presents for her kids and preparing Christmas decorations with them, and she had bought some nice clothing for herself. The elaboration of these exceptions provided an upward implicative force that supported a more general indicator of her "overcoming difficulties," which eventually transformed into the overall evaluation that she was valuing small things that she had given up in the past and that now (in the consolidation phase) represented a difference that makes a difference.

In the above case, the therapist initially intervened at the middle level (indicators).

That is, after listening to the initial series of negative episodes described above, he asked about doing something for herself in spite of all the difficulties and from there sought specific positive episodes. In response, the client then recalled the day when she had "forced" herself to cook for a visitor and the series of other exceptions described above. Thus, once the focus of the conversation shifted to more positive indicators, a new downward contextual force allowed the client to realize that some exceptional episodes had already happened, which, as the session proceeded, became relevant signs of "things getting better" (a general evaluation of improvement).

A therapist could also intervene initially at the most specific level (episodes). For example, a different client said things were not better (an evaluation) and illustrated this with negative indicators (e.g., obsessions and "crazes" that overwhelm her) as well as specific episodes ("becoming annoying" and not letting her Mum sleep; "almost cutting" herself for having lost a job). In the deconstruction phase, the therapist began at the level of these specific episodes, working with her to construct several small differences and resources that might have been useful (e.g., being "less annoying" with her Mum on certain occasions; things that helped her to calm down when she lost a job and prevented her from cutting herself). The collection and elaboration of a series of specific episodes that were exceptions—and their contrast with similar situations in the past—seemed to exert an upward implicative force. The indicator level shifted from "overwhelming obsessions" to a "certain feeling of self-control," which in the consolidation phase resulted in a positive evaluation of the present situation as better.

Still another therapist intervened first at the most general level (evaluation). The client initially reported that things were not better and moved downward from this evaluation to the indicator that she was feeling insecure about her ex-husband, and specific episodes such as a tense argument with her ex-husband. This therapist began deconstruction at the most general level by challenging her initial report, until the client started questioning this evaluation herself, denying the idea that "everything is awful." This seemed to have exerted a downward contextual force on the indicators, which in the elaboration phase changed gradually from "feeling insecure" to "being clearer" about her desires. Thereafter, the episodes acquired a different meaning for her, for example, "a tense argument" became an "opportunity to realize" that she did not love him.

In short, a hypothetical change mechanism for deconstructing initially negative reports could be the progressive construction of topics relevant to the client, through the upward and downward forces that episodes, indicators, and evaluations exert.

DISCUSSION

Implications for Practice

At the beginning of this project, starting from a list of deconstruction questions and a general definition of deconstruction (de Shazer, 1988), it seemed that it might be possible to uncover a relatively simple pattern of therapeutic interviewing, which

would be useful for achieving the deconstruction of initially negative reports. However, there was no single way that the therapists in our sample accomplished (or did not accomplish) deconstruction. Specific conclusions about possible differences between excerpts that ended with improvement and those that did not are limited. There were several different ways to proceed. For example, therapists intervened in two different ways (the direct and the indirect approach), but both approaches could be found for either outcome. Instead of a fixed formula, several discoveries emerged:

First, this study suggests that deconstruction of clients' initial no-improvement reports is best seen as a complex process that involves more than simply using deconstruction questions and then moving on to elaborate on exceptions. In fact, deconstruction per se seems to be only one phase in a more extended process that can include up to five different phases. These phases do not necessarily follow a fixed order, as therapists and clients may move back and forth from one phase to another, depending on each other's responses. Seen from this perspective, deconstruction of no-improvement is related to the broader theme of the construction of change, a process that might extend over a whole session.

Second, although solution-focused therapists might be inclined to focus on solutions from the beginning of every session, these data suggest that often it might be necessary to initially join the client who is stating that things have not improved. Connection with client's problem-centered discourse may be an important part of the deconstruction process, both as the starting point of the indirect approach and as a possible resource to come back to if difficulties appear in the deconstruction phase or the elaboration phase.

A third discovery was the value of alternative topics. Our assumption before carrying out this study was that asking clients about future steps and hypothetical solutions was the natural option only *after* actual improvements had been described and expanded. In contrast, the findings suggest that another good option may be to discuss alternative topics that might generate talk about improvement. Questions such as "What will be the first small sign that you will see happening once things get better?" (future improvement) or "Well, suppose that you had handled his tantrum differently last week, how would he have noticed?" (hypothetical solution) may be useful options in the preparation phase. For some clients, it might be easier to move from negative to alternative topics and then on to positive ones than to move directly from negative to positive in the deconstruction phase. The focus on future scenarios or hypothetical situations might also help clients to generate realistic expectations (Lloyd & Dallos, 2006).

Fourth, the data suggest that understanding therapist-client exchanges from the perspective of ordered generality/specificity levels might be useful in SFBT. Coordinated Management of Meaning (Pearce & Cronen, 1980) offers an interesting theoretical framework for the understanding of in-session change. At the practice level, it is possible that moving from episodes to indicators and evaluations and vice-versa is an invitation to include narrative questions (White & Epston, 1989) in SFBT sessions. Especially in the elaboration phase, these may be a way to "thicken" the description of exceptions (Paré, 2010).

Finally, relevance seems to be a central element of the overall deconstruction process. Seen from this perspective, the job of the therapist is not only to locate specific improvements or exceptions (i.e., the deconstruction phase). Therapists must also keep a global perspective on the therapeutic process, constantly checking with their clients the implications and meaning that these improvements have in relation to their broader therapeutic goals (i.e., the consolidation phase). For example, if the therapist insists prematurely on evaluating those "small things done in spite of everything" as an important advance, the client could reply something like "Can't you see that I'm not doing anything special for me, just trying to survive day to day? I've said that I feel really bad."

Limitations and Future Possibilities

There are necessarily limitations to any qualitative study (Elliott & Williams, 2001). In spite of all precautions, there is always the risk of confirmatory skew, in which the researchers tend to find what they expect (Glaser & Holton, 2004). The fact that there were many unexpected insights suggests that this was not a major problem in this research project.

The small sample was carefully selected and matched, but it was limited to SFBT sessions conducted at one clinical service. The decision to include sessions of both trainees and trainers is both a weakness and a strength of the study. It could be argued that trainees are not as competent as trainers in handling a complex process like deconstruction, but analyzing the sessions of therapists with varying degrees of expertise brings this study closer to real-world practice.

Future research to clarify further the conditions that make deconstruction helpful could make use of triangulation (Mertens, 1998), by including both therapists' and clients' perspectives about what makes the difference in those sessions that end with improvement. It would also be useful to take into account the possible moderating effect of the therapeutic relationship: It might be that a good therapeutic alliance allows therapists to use the direct approach in the deconstruction process, whereas a less solid alliance might make an indirect approach more advisable. Finally, it would be interesting to conduct quantitative sequential analyses (Bakeman & Gottman, 1986) of how therapeutic interaction unfolds moment-by-moment, in order to test specific hypotheses on the deconstruction process.

REFERENCES

Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, *27*, 371–393.

Bakeman, R., & Gottman, J. M. (1986). *Observing interaction: An introduction to sequential analysis.* New York, NY: Cambridge University Press.

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

Beyebach, M. (2006). *24 ideas para una psicoterapia breve* [24 ideas for a brief psychotherapy]. Barcelona, Spain: Herder.

Beyebach, M., & Carranza, V. (1997). Therapeutic interaction and dropout: Measuring relational communication in solution-focused therapy. *Journal of Family Therapy*, *19*, 173–212.

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

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

De Shazer, S., & Berg, I. K. (1992). Doing therapy: A post-structural re-vision. *Journal of Marital and Family Therapy, 18,* 71-81.

Elliott, M. S., & Williams, D. I. (2001). Paradoxes of qualitative research. *Counseling and Psychotherapy Research*, *1*, 181–183.

Franklin, C. (1996). Solution-focused therapy: A marital case study using recursive dialectic analysis. *Journal of Family Psychotherapy*, *7*, 31–51.

Gale, J., & Newfield, N. (1992). A conversation analysis of a solution-focused marital therapy session. *Journal of Marital and Family Therapy*, *18*, 153–165.

Glaser, B. G., & Holton, J. (2004). Remodeling grounded theory. *Forum Qualitative Sozialforschung*, *5*, Paper 4. Retrieved June 12, 2006 from http://www.qualitative-research.net/fqs-texte/2-04/2-04glaser-e.htm

Greenberg, L. S. (1984). Task analysis: The general approach. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change* (pp. 124–148). New York, NY: Guilford.

Herrero de Vega, M., & Beyebach, M. (2004). Between-session change in solution-focused therapy: A replication. *Journal of Systemic Therapies*, *23*(2), 18–26.

Lloyd, H., & Dallos, R. (2006). Solution-focused brief therapy with families who have a child with intellectual disabilities: A description of the content of initial sessions and the processes. *Clinical Child Psychology and Psychiatry*, *11*, 367–386.

Mertens, D. M. (1998). *Research methods in education and psychology*. Thousand Oaks, CA: Sage.

Mühr, T. (1996). *Atlas.ti short user manual.* London: Scolari.

Nau, D. S., & Shilts, L. (2000). When to use the miracle question: Clues from a qualitative study of four SFBT practitioners. *Journal of Systemic Therapies*, *19*, 129–135.

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

Paré, D. (2010, January). *Thickening the solution-focused soup*. Workshop presented at the Pontifical University of Salamanca, Salamanca, Spain.

Pearce, W. B., & Cronen, V. E. (1980). *Communication, action and meaning: The creation of social realities.* New York, NY: Praeger.

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

Rhodes, R., & Greenberg, L. S. (1994). Investigating the process of change: Clinical applications of process research. In P. F. Talley, H. Strupp & S. Butler (Eds.), *Psychotherapy research practice: Bridging the gap* (pp. 227–245). New York, NY: Basic Books.

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

Tomm, K. (1987a). Interventive interviewing: Part I. Strategizing as a fourth guideline for the therapist. *Family Process*, *26*, 3–13.

Tomm, K. (1987b). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process*, *26*, 167–183.

Trepper, T. S., Dolan, Y., McCollum, E. E., & Nelson, T. (2006). Steve de Shazer and the future of solution-focused therapy. *Journal of Marital and Family Therapy*, *32*, 133–139.

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