

MICROANALYSIS OF POSITIVE AND NEGATIVE CONTENT IN SOLUTION-FOCUSED BRIEF THERAPY AND COGNITIVE BEHAVIORAL THERAPY EXPERT SESSIONS

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The models of cognitive behavioral therapy (CBT) and solution-focused brief therapy (SFBT) differ in their primary focus: problem solving versus solution building. These theoretical differences imply dissimilar practices, including the content of the therapeutic dialogue. Specifically, CBT sessions should include more talk about negative topics in clients' lives such as problems and situational difficulties, whereas SFBT sessions should focus on positive topics in clients' lives such as strengths and resources. We tested whether expert practice reflects these differences in the models. A reliable microanalysis revealed that demonstration sessions by three experts in each model differed significantly in the expected directions: negative content was significantly higher in CBT than SFBT sessions, and positive content was significantly higher in SFBT than CBT sessions. There was also a significant tendency for clients to respond in kind (i.e., negative therapist content was followed by negative client content, and positive therapist content by positive client content).

Both solution-focused brief therapy (SFBT) and cognitive behavioral therapy (CBT) have demonstrated their effectiveness in randomized controlled trials (e.g., Butler,

This project was supported by a seed grant from Texas Tech University. Special thanks go to Christine Tomori, who provided details of her analysis system and to Jennifer Gerwing, who developed the statistical analysis. Fuller details of procedure and results are available from the first author.

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Chapman, Forman, & Beck, 2006; Kim, Smock, Trepper, McCollum, & Franklin, 2010). However, there is little systematic research evidence about what happens within these therapies and how they may differ in what the therapists actually do. We have proposed elsewhere in this special section that microanalysis of the moment-by-moment details of communication in actual therapy sessions can begin to provide such evidence (e.g., De Jong, Bavelas, & Korman, 2013). The present study used microanalysis to examine the content (topics) of therapists' and clients' communication in three sessions by SFBT experts and three sessions by (CBT) experts. There were four broad research questions:

1. Are there differences between these approaches in what the therapists actually talk about?
2. Are these differences consistent with their theoretical models?
3. Are there differences within each model?
4. Do these differences affect clients within a session?

Specifically, our microanalysis focused on positive and negative content. *Positive content* is talking about any positive aspect of the client's life in the past, present, or future, such as the client's resources, solutions, exceptions to the problem, good life situations, or hope. *Negative content* is talking about any negative aspect of the client's life in the past, present, or future, such as the client's problem, complaints, lack of resources, bad life situation, or inability to see a solution. It is important to emphasize throughout this article that the terms *negative* and *positive* solely refer to the content of topics in the dialogue, not to the value or desirability of talking about any particular topic. Also, our operational definitions are highly contextual, so that whether a particular topic is positive or negative in a client's life depends on the individual client, the immediate context in which the topic arises, and how the topic is phrased at that moment.

SFBT AND CBT: SIMILARITIES AND DIFFERENCES

In broad terms, there are some similarities between CBT and SFBT (e.g., Beck, 1995; de Shazer, 1986; National Association of Cognitive-Behavioral Therapists [NACBT], 2009). Both focus on cognitions and behaviors. Both can be brief because, rather than aiming to alter the personality of a client, they deal with the presenting topic. In addition, they use a few similar techniques such as assigning homework, the use of scaling questions, and goal setting.

Beyond these similarities, there are several important differences. First, CBT subsumes a broad spectrum of more specialized CBT orientations and approaches (Dobson & Dozois, 2002). CBT includes approaches such as behavior therapy, cognitive therapy, dialectical behavior therapy, rational emotive behavior therapy, and mindfulness-based cognitive therapy, each with its own theory of behavior

change, which could potentially lead to heterogeneous practices. In contrast, de Shazer and Berg created SFBT as a solution-building model with distinct interventions using a highly disciplined set of communicative practices (e.g., De Jong & Berg, 2013). Thus, SFBT therapists are more likely to deliver therapy in a homogeneous manner.

Second, CBT and SFBT therapists make different assumptions about their clients. CBT therapists view clients as having unhealthy or faulty cognitions that lead to problematic behaviors (Beck, 1979). SFBT therapists assume that clients possess all of the resources they need, so there is no need to identify deficiencies or pathologies. Such contrasting assumptions affect the delivery of therapy in important ways. CBT therapists take an expert position and challenge distorted cognitions (e.g., Clark, 1995; Ellis, 1962) while SFBT therapists take a “not-knowing” stance (Anderson & Goolishian, 1992), asking questions to highlight client resources and exceptions rather than to arrive at a diagnosis. Thus, while CBT therapists focus on helping clients change their faulty thinking (Beck, 1979, 1995), SFBT therapists do not try to find or change faulty thinking; their goal is to help clients articulate the details of their desired future (Pichot & Dolan, 2003).

A third major difference between the two models is solution building versus problem solving. CBT is a problem-solving approach, in which the therapist seeks to identify problems and then generate the best response to fit a specific problematic situation. This approach also includes teaching clients how to select the most effective response to their problem (Beck, 1995; D’Zurilla & Goldfried, 1971). The key to problem solving is finding the best solution for the presenting problem. In contrast, solution building involves generating ideas about how things could be better in the future despite the presence of the current problem (de Shazer, 1986). Solutions involve the client “doing something different to become more satisfied with his or her life” (de Shazer, p. 49). The goal is not to eliminate the problem but to construct the client’s desired future (a solution) despite life’s circumstances. Because their goals differ, problem solving and solution building are distinct processes.

Fourth, CBT and SFBT differ in their assumptions about the role of language in psychotherapy. CBT treats language simply as means for transmitting information back and forth (Persons & Davidson, 2002), whereas SFBT treats language as influential in itself, as the tool for co-constructing realities (de Shazer et al., 2007). For example, CBT therapists ask questions in order to gather more information about problematic thoughts and behaviors in order to change faulty thinking. SFBT therapists ask questions to introduce new possibilities and co-construct new meanings (e.g., McGee, Del Vento, & Bavelas, 2005). In this view, therapists and clients are not simply sending information about the client back and forth to each other. Their dialogue is actively shaping a new version of the client’s life.

Although some CBT and SFBT techniques may appear similar, on closer examination of the language of these techniques, differences emerge. For example, both CBT and SFBT ask scaling questions but use different anchor points. A CBT

therapist often asks clients to rate *how bad* an experience was or *how bad* is the level of the problem that the client is experiencing (e.g., from 1 = “good”) to 10 = “bad”). SFBT scales are anchored positively; for example, the therapist would ask a client to rate his or her goals, confidence, or hope on a scale of 10 as the desired (“good”) outcome and 1 (or 0) as furthest from the desired outcome; both end points would use the client’s language. CBT scales are also nomothetic, with the same meaning for all clients (e.g., 5 is the middle of the therapist-defined scale). SFBT scales are idiographic, that is, defined by the individual client. SFBT therapists might set the direction of the anchor points, but the client decides what everything in between represents. For example, the therapist talks about the 5 with the client and asks the client to assign his or her own meaning to that number. CBT and SFBT interventions such as homework and goal setting differ along the same lines. Although these differences seem subtle, they are important both in practice and in the assumptions they reflect.

Implications and Predictions

All of the above differences affect the content of therapeutic communication. Based on the CBT model, a therapist would assume client deficiencies, take an expert stance, and use a problem-solving approach. Therefore, it is appropriate for CBT therapists to talk more about problems and negative content, whereas the goals and assumptions of SFBT therapists lead them to talk more about solutions and positive content (de Shazer, 1994, chapter 7; Tomori, 2004; Tomori & Bavelas, 2007). It is important to re-emphasize that, our operational definitions of *positive* and *negative* content are highly contextual, that is, determined by the individual client, the moment at which the topic arises, and how the way it is presented at that moment. In general, *negative content* focuses on a negative aspect of the client’s life in the past, present, or future. Typical examples of negative content include talking about the client’s problem, complaints, lack of resources, bad life situation, or inability to see a solution. *Positive content* focuses on a positive aspect of the client’s life in the past, present, or future. Specific examples include client’s resources, solutions, exceptions to the problem, good life situations, or hope.

Distinguishing between positive and negative therapist content allows us to address specific questions about communication by CBT and SFBT therapists. We predict, first, that the proportions of positive and negative content will differ in ways that are consistent with their models: The talk of SFBT therapists will be more positive than that of CBT therapists, which will be more negative than SFBT therapists. Second, because SFBT is a homogenous model, specifically focused on positive language, we predict these therapists will be homogeneous in this respect, whereas the potentially heterogeneous CBT therapists would not be. Third, because the therapist contributes to the co-construction of the session, we predict that the therapist’s positive or negative content would affect the client’s subsequent content and the overall course of the session.

METHOD

Data

The sessions analyzed here met three criteria: (1) the therapist was a founder of or acknowledged expert in SFBT or CBT and was a good exemplar of their model, so the video was a prototype offered for training others in their approach, (2) the video was published and therefore available for readers to view for themselves, and (3) the SFBT and CBT sessions were as comparable as possible, given the constraints of the first two criteria. The data selected were six full-length published therapy sessions; their length ranged from 32 min, 47 s to 51 min, 30 s with a median of 45 min, 20 s.

- SFBT: Insoo Kim Berg (Solution-Focused Brief Therapy Association [SBTA], 2008b). An adolescent boy had attempted suicide the night before.
- SFBT: Steve de Shazer (Solution-Focused Brief Therapy Association, 2008a). An older woman came because of difficulty sleeping.
- SFBT: Yvonne Dolan (Solution-Focused Brief Therapy Association, 2008c). A young woman is struggling with getting on with her life after a drug overdose.
- CBT: Jacqueline Persons (American Psychological Association [APA], 2006a). A young woman is overcoming a social phobia.
- CBT: Peter A. Lichtenberg (American Psychological Association, 2006b). An older woman asked for help in controlling her temper with her husband.
- CBT: Donald Meichenbaum (American Psychological Association, 2007). A young woman had made several suicide attempts in her life.

Analysis

All of the definitions used in this analysis are available from the first author, with full examples and procedures. The analysts (SS and AF) analyzed all of the therapist's utterances (speaking turns) in three stages (looking first for positive content, then negative content, then content that was neither positive nor negative), followed by all of the client's utterances in the same three stages. They assessed reliability regularly and resolved any disagreements.

Analyzing Therapist Content

Positive Analysis. First, each analyst examined everything the therapist said in the session, utterance by utterance, looking for any parts of each utterance that were positive. Positive therapist content included questions, statements, formulations, suggestions, etc., by the therapist that focused the client on some positive aspect of the client's life (e.g., a relationship, trait, or experience in the past, present, or future). Examples of positive therapist content included client strengths or abilities, exceptions to the client's problem, resources (in the client or in the client's

situation), client's agency toward change, and asking the client what will be helpful (see Table 1 for more positive topics). Two examples of positive therapist content (in italics) occurred in the following excerpt, when a client was describing how a social interaction had gone well:

CL: It was ok.

TH: *Ok. It sounds like it kind of flowed naturally from one thing to the other.*

CL: Yeah it did, it did.

TH: *I think, I think that's a plus for you.* (APA, 2006a)

Another example was a question that presupposed the client had been able to find a solution:

TH: *How did you find your way out of this the last time?* (SFBTA, 2008b)

Negative Analysis. Next, the analysts independently viewed the session again, utterance by utterance, in order to find negative therapist content. Negative

TABLE 1. Examples of Positive and Negative Topics

Positive topics	Negative topics
Solutions	Problems, weaknesses, or complaints
Resources (in the client or in the client's situation)	Lack of resources, including financial or personal
Agency toward change	Feeling out of control
Confidence	Lack of confidence
Initiative	Lack of agency; inertia
Strengths or abilities	Helplessness
Exceptions to the problem (e.g., past successes)	Generalizing the problem; seeing no exceptions
Good situations in a person's life (e.g., support of others; a good job)	A bad situation (e.g., other people, lack of money)
Commenting on where he/she wants to be	Failure or fear of failure
Stating what will be helpful	Inability to see a solution
Displaying optimism, hope about their situation	Pessimism, lack of hope; hopelessness
Noting that something went well; positive emotions	Negative emotions (e.g., fear, anxiety, depression, guilt)
Positive presuppositions in questions	Negative presuppositions in questions
Details of preferred future	How difficult this problem is

therapist content included questions, statements, formulations, suggestions, etc., by the therapist that focused the client on some negative relationship, trait, or experience in the past, present, or future. Examples of negative therapist content included a bad situation (e.g., other people, lack of money), the client's helplessness, the client's feeling out of control, the client's lack of agency, generalizing the problem or seeing no exceptions, and negative presuppositions in questions (see Table 1 for more negative topics). For example, when a client had described having a difficulty with her neighbor and yet being unable to move, the therapist responded:

TH: *Right. So you're pretty well stuck with him?* (SFBTA, 2008a)

In another example, the therapist returned to the topic of the client's conflict with her husband:

TH: *Now let's, let's go back to the incident where you had the butcher knife. What was that all about?* (APA, 2006b)

Both Positive and Negative. It was also possible for an utterance with positive content to have negative content in another part; these utterances would ultimately be called both positive and negative. For example, a client had described how he had avoided a family conflict by being assertive (positive content) but that he had not subsequently found help for his crisis (negative content), and the therapist summarized:

TH: *. . . and last night sounds like you were being assertive, was helpful for you.*
(Cl: Right) *Right, and somehow you were, quite didn't know what to do with it after that, after being assertive. So, you went to your aunt's house. (Cl: um hmm) And that wasn't very helpful?* (SFBTA, 2008c)

Neither Positive nor Negative. Finally, the analysts checked that utterances without a rating so far were truly neither positive nor negative (e.g., minimal listening responses, such as "M-hm").

Analyzing Client Content

Next, the analysts applied essentially the same broad definitions to the client utterances. One new possibility occurred when the therapist sought an answer or confirmation from the client and the client's response was simply "yes" or "no" (or the equivalent), then the content of the therapist's utterance determined the rating of the client's response (e.g., answering "No" to "Are you worried about this?" would be positive client content).

Reliability

The two analysts assessed their reliability frequently in order to ensure that they were not drifting from the rules. Reliability was calculated as a percentage, that is the number of utterances the analysts agreed on, divided by the number of utterances analyzed, times 100. Reliability for the six therapists ranged from 75.3% to 87.9% with a median of 84.9%. For the six clients, the range was 69.4% to 87.1% with a median of 80.1%.

RESULTS

The upper half of Table 2 shows the frequencies of positive and negative utterances for individual therapists. Figure 1 summarizes all of the individual data graphically, that is, the relative proportions of each therapist's utterances that were positive, negative, both positive and negative, neither positive nor negative, or not analyzable.

TABLE 2. Frequencies of Positive Versus Negative Therapist Utterances as a Function of Therapist Model

Therapist utterances	Positive	Negative
Individual therapists		
SFBT: Berg	54	16
SFBT: de Shazer	52	14
SFBT: Dolan	92	7
CBT: Lichtenberg	21	83
CBT: Meichenbaum	40	25
CBT: Persons	33	31
All therapist utterances**		
SFBT total	198	37
CBT	94	139
$\chi^2(1, N = 468) = 96.15, p < .0001$		
After client utterances with both positive and negative content*		
SFBT	29	8
CBT	5	14
After client utterances with neither positive nor negative content**		
SFBT	29	5
CBT	15	24

* $p < .0002$. ** $p < .0001$.

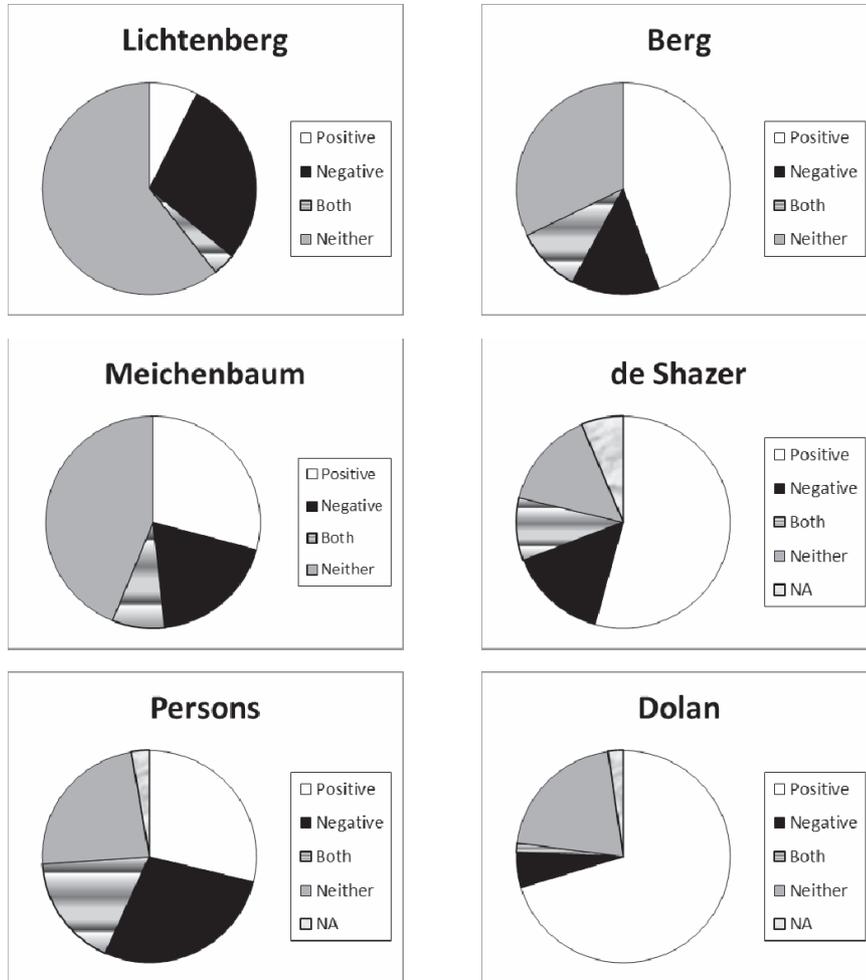


FIGURE 1. Proportions of each rating for the individual therapists. Each utterance could be positive, negative, both positive and negative, neither positive nor negative, or not analyzable.

The first hypothesis was twofold. Because positive and negative content had been assessed independently, we predicted both that the content of SFBT sessions would be more positive than that of CBT sessions and also that the content of CBT sessions would be more negative than SFBT sessions. The lower half of Table 2 shows three different ways to test the hypothesis that the SFBT and CBT therapists would differ in their proportions of positive versus negative content (when the other ratings were

excluded). The first test was an omnibus chi-square, which confirmed that the SFBT therapists' utterances were significantly more likely to be positive and less likely to be negative than those of CBT therapists. Then, in order to eliminate the possibility that the therapists were simply echoing their clients' content (e.g., responding to negative client utterances with negative content), the second test examined what therapists did when the client's utterance had been both positive and negative. The SFBT therapists were significantly more likely to respond to these mixed utterances with positive content, and the CBT therapists were more likely to respond with negative content. The third test examined how the therapists responded when a client's utterance had been neither positive nor negative. The SFBT therapists were significantly more likely to respond to these utterances with positive content, and the CBT therapists were more likely to respond with negative content.

Taken together, the three results confirmed our first hypothesis that the language of the SFBT therapists tended to be more positive than that of CBT therapists, who tended to be more negative than SFBT therapists. Both in their overall choice of conversational content and in their immediate responses to clients' utterances, the SFBT therapists as a group as well as the CBT therapists as a group were consistent with their models and significantly different from each other.

Our second hypothesis was that the SFBT therapists would be homogeneously positive. This hypothesis is not statistically testable, but as shown in Figure 1 and Table 2, each of the SFBT therapists used more positive than negative content. In contrast, the CBT therapists differed widely: more positive than negative (Meichenbaum), more negative than positive (Lichtenberg), and equal proportions of positive and negative (Persons). Thus, our second hypothesis was confirmed; the SFBT therapists were highly similar while CBT therapists were quite diverse. These results are consistent with the diversity of practices encompassed by CBT and the relative homogeneity of SFBT.

Our third hypothesis was that clients would respond in kind to their therapist's positive or negative content; chi-squares confirmed this hypothesis for each therapist (all $ps < .0002$ and for all six therapists combined, $p < .0001$). The combined data showed that when the therapist had said something positive, the client responded with a positive utterance 180 times and with a negative utterance only 14 times. When the therapist had said something negative, the client responded with a negative utterance 111 times and a positive utterance only 21 times. These results suggest that, regardless of approach, the therapist's choice of positive versus negative content has an immediate effect on the client's talk.

DISCUSSION AND IMPLICATIONS FOR PRACTICE

The findings for the SFBT therapists were entirely congruent with their model and with each other, at least in the one important feature analyzed here. Overall and individually, they produced significantly more positive than negative utterances,

which supports SFBT's approach of focusing on a positive outlook (Walter & Peller, 1992). The clients' responses to these positive choices were overwhelmingly positive, as the SFBT model would predict. This finding is important because it shows that these SFBT therapists' choice to build on clients' strengths and resources had an impact on how clients respond within the session. Also as predicted, the CBT experts were significantly more likely to use (and to perpetuate) negative content. Thus, in terms of the positive versus negative content of their sessions, these are quite different approaches to therapy.

Given these findings, practitioners may wish to examine the content of communication in their own sessions, including how this may be influencing the client. Many therapists would say that what we are calling negative content is essential to therapy. In this view, clients come to therapy for their problems, and solving these problems necessarily requires talking about negative content; content that is primarily positive would not address crucial issues. However, Gassmann and Grawe's (2006) research on problem activation versus resource activation found that resource activation was a necessary component of successful therapy outcomes. Resource activation entails interventions that focus on the healthy aspects of a person's personality (de Shazer, 1988; Gassmann & Grawe, 2004), so it is likely to consist of primarily positive content. In contrast, problem activation, such as having a client experience painful emotions in a session, would usually be negative content (Gassmann & Grawe, 2006). They found that focusing on the client's healthy characteristics was related to successful outcomes, which supports the view that there is an important role for positive content in therapy.

These results can aid in the supervision and training of the SFBT model in several ways. One way to apply this research in SFBT supervision is to have the supervisee record and microanalyze his or her therapy sessions using the guidelines in Table 1, that is, looking specifically for any client utterances that had *both positive and negative content*. Then the supervisee could identify (a) what he or she did after the client had offered both positive and negative content and (b) how their own subsequent choice affected the client's next response. Knowing these effects can help supervisees modify their language, if necessary, to resemble more closely the language assumptions of SFBT. It can also help supervisees become more mindful about solution building through emphasizing positive content. Another advantage of having supervisees analyze the content of their own sessions is to teach them to focus on the details of their talk and word choice, rather than on their intentions or what they were hoping to convey. Supervisees will often intend to be solution-focused, but what they actually say may not be solution-focused. (See Smock, 2010, for an example of using microanalysis in supervision.)

An SFBT training exercise that is ideal for larger audiences starts with teaching participants the definitions of positive and negative content. This can be done by showing short video examples, with transcripts, and asking participants in small groups to identify positive and negative content. Discussion of the groups' analysis

decisions will clarify the definitions. This can lead to a broader exercise that begins with a new one-minute video excerpt, with transcript, of an SFBT expert session. The trainer divides the audience into three groups, assigning a different task to each group: (1) write down the details of the *therapist's language*, including type of content (positive or negative), (2) write down the details of the *client's language*, including type of content (positive or negative), or (3) write down everything you notice about the *interaction between the therapist's language and the client's language*, including whether they are both talking equally, whether they agree or disagree, and how the client responds to the therapists' language. The trainer then asks each group to share what they observed from the therapy clip. Next, the trainer then shows another one-minute clip, with transcript, of a session by an expert in a different (non-SFBT) model and asks the three groups to repeat their previously assigned task for this excerpt. The trainer then asks each group to share what they observed from the second video. The final discussion is a comparison of the two therapy sessions. This exercise can help trainees begin to take a detailed and critical look at the observable communication differences between SFBT and other models.

We have focused these exercises on the training of SFBT (and not CBT) therapists because of the other major finding of our study, namely, the heterogeneity among the CBT experts in the content of their sessions. Their differences are consistent with the explicit position that

cognitive-behavioral therapy does *not* exist as a distinct therapeutic technique. The term "cognitive-behavioral therapy (CBT)" is a very general term for a classification of therapies with similarities. (NACBT, 2013, home page; emphasis original)

The present results confirmed that these three CBT experts did not share distinct therapeutic techniques that would lead to similar proportions of positive or negative topical content in their sessions. This diversity presents a conundrum for CBT trainers: If CBT is not a distinct model, then which practices should be taught? The details of microanalysis are useful in training because they provide concrete examples of how to practice a given model (Smock, 2010). However, based on the present results, CBT trainers would have to choose which specific practices they wish to teach.

Microanalysis of communication in psychotherapy is still a new method, but it is rapidly developing as an objective, quantitative approach to study therapist-client interactions. This study adds to the research base of SFBT and provides applications of microanalysis in the practice and training of the model.

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