THESIS

Protocol for a qualitative study on the therapy process between solution-focused cognitive and systemic therapists and their clients.

Robin Quagebeur

Korzybski Institute

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Abstract

Psychotherapy has gained substantial scientific evidence for its efficacy, eliminating debates regarding its effectiveness. However, the specific elements of psychotherapy processes and the influence of client engagement on therapy outcomes are of interest for further exploration.

This research protocol proposes to investigate the Solution-Focused Cognitive and Systemic Therapy (SFCST) process and its effectiveness by examining clients' perceptions by thematic analysis of its beneficial aspects and how these perceptions vary based on the level of engagement within the client-practitioner relationship.

Once executed, this research intends to contribute to the knowledge of psychotherapy processes and raise awareness about the SFCST model within the scientific community. The research will be conducted in a natural setting with adult clients receiving individual solution-focused therapy in private practice.

Scientific evidence for psychotherapy.

Despite criticisms, the efficacy of psychotherapy is now firmly established and no longer a subject of debate. Beginning in the 1950s and continuing through the 1980s, scholars engaged in heated debates regarding the effectiveness of psychotherapy, with initial criticisms (Eysenck, 1952; Rachman, 1971) primarily stemming from behavioral critiques of psychoanalytic theory. The history of psychotherapy has seen rivalry and competition among different theoretical orientations, each claiming superiority over the others. Rather than focusing on absolute efficacy, the debate mainly revolved around the relative effectiveness of different treatment approaches. While the initial meta-analyses (Smith & Glass, 1977) faced controversy, the results of both the original and subsequent meta-analyses have ultimately led to the consensus that psychotherapy is highly effective (Wampold & Imel, 2015).

Early in the field's history, Saul Rosenzweig observed that the outcomes were generally similar despite the differences among various therapies. He referred to the general equivalence of benefits as the "Dodo bird effect" and introduced the concept of common factors (Rosenzweig, 1936). Common factors are therapy aspects shared among most psychotherapies, such as hope, expectation, relationship with the therapist, belief, and corrective experience. While there have been several theoretical models of common factors, they have largely remained on the periphery. Accepting common factors as the main cause of psychotherapy benefits could challenge the fundamental assumptions of modern psychotherapy, leading to resistance from proponents of specific treatments.

The approach of the Bruges model (Isebaert, 2016) of Solution-Focused Cognitive and Systemic Therapy (SFCST) can function as a meta-model that emphasizes the therapeutic alliance (as a common factor), especially client factors, placebo factors, and therapist factors. Client factors pertain to the client's goals, resources, and skills. It's essential to recognize that clients bring their unique objectives, strengths, and abilities to therapy. Placebo factors refer to hope and expectations. Hope promotes motivation and optimism in clients and enables them to envision a better future. Therapist factors involve the therapist's skills, attitude, and belief in the client's resources. It is the therapist's job to cultivate a context where clients can find solutions that suit them.

Why this research protocol?

In Belgium, the Solution-Focused Cognitive and Systemic Therapy (SFCST) model has often been underexposed compared to other therapy models. This underrepresentation can lead to a lack of visibility and credibility for the SFCST approach within the mental health care community.

The primary goal of this research project is to provide a qualitative understanding of the specific elements of the SFCST process that clients perceive as most beneficial while also exploring how these perceptions might vary based on the level of engagement within the client-practitioner relationship. This research project has the potential to serve as a platform for raising awareness about the SFCST model within the scientific community by disseminating the findings through publications, presentations, and other channels. We hope this will ignite further interest in and appreciation for the SFCST approach.

It is important to recognize that research on the SFCST would not have been possible without the contributions of the pioneers and innovators of the SFCST model, notably the Korzybski Institute, and more specifically Dr. Luc Isebaert and his colleagues. Building upon their work, we hope to eventually make a small contribution to the ongoing growth and development of the SFCST model, strengthening the approach's credibility within the mental health care community.

Process research in psychotherapy

Closely related to the common factor models are efforts to characterize and examine hypotheses concerning the psychotherapy process. Process research in psychotherapy, which examines the events and experiences during therapy sessions leading to patient change, has roots in Rogers' client-centered therapy. Since then, process research has expanded into various theories and approaches, aiming to shed light on the mechanisms behind successful therapy.

Critical aspects of process research in psychotherapy include:

- Therapeutic Relationship: Factors such as empathy, genuineness, and unconditional positive regard have been shown to influence the effectiveness of therapy. Process research examines the dynamics of the therapeutic relationship and how it fosters change.
- In-session processes: Process research investigates specific events and experiences within therapy sessions. These can include moments of insight, emotional expression, and specific therapeutic techniques. Researchers may analyze transcripts, recordings, or observational data to identify patterns and understand how these in-session events contribute to client change.

- Client Factors: Clients bring their unique personalities, experiences, and perspectives to therapy. Process research seeks to understand how these factors interact with the therapeutic process and contribute to change. This can involve exploring clients' expectations, motivations, and resources. In solution-focused work, therapists look for (partial) solutions that are already present.
- Therapist Factors: Therapists also have unique qualities, such as personality traits, theoretical orientation, and clinical experience. Process research examines how these factors impact the therapeutic process, influencing the techniques therapists choose and the effectiveness of their interventions.
- Stages of Change: Process research may also investigate how clients progress through different stages of change during therapy. This can involve identifying markers of change, exploring factors that facilitate or hinder progression, and understanding how these stages relate to therapeutic outcomes.

By studying the psychotherapy process, researchers can gain insights into the mechanisms underlying successful therapy and provide valuable information to therapists, helping them enhance their practice and improve client outcomes. Various methods can be employed to study the psychotherapy process. Some of these methods include:

- Session Transcripts: Analyzing written transcripts of therapy sessions can help researchers examine the therapeutic dialogue, interventions, and client responses.
- Audio and Video Recordings: Recording therapy sessions allows researchers to study verbal and non-verbal cues, along with the tone, pacing, and emotional expression of clients and therapists.
- Observational Coding Systems: Researchers can use established coding systems to analyze transcripts or recordings systematically. These systems often involve categorizing specific therapeutic behaviors, interventions, and in-session events to identify patterns and relationships between various aspects of the therapy process.
- Self-report Measures: Clients and therapists can provide insights into their experiences through self-report measures, such as questionnaires and interviews. These methods can help researchers understand individual perspectives on the therapeutic process and outcomes.
- Process-Outcome Research: This approach examines the relationship between specific therapy process variables (e.g., therapeutic alliance, interventions) and therapy outcomes (e.g., symptom reduction, improved functioning).
- Qualitative Research: Qualitative methods, such as thematic analysis, grounded theory, or interpretative phenomenological analysis, can explore the therapy process in-depth. These

approaches often involve inductive analysis of transcripts, recordings, or interviews to identify themes, patterns, and meanings related to the therapeutic process.

- Case Studies: In-depth case studies can provide insights into the therapy process for individual clients. This approach often involves a detailed examination of session transcripts, recordings, or other data sources to understand the unique aspects of a client's therapy experience.
- Single-Session Research: Focusing on single therapy sessions can allow researchers to explore specific events or interventions in detail, providing a micro-level understanding of the therapy process.

Within this research project, a **thematic analysis** will serve as a tool for understanding clients' experiences, beliefs, and attitudes regarding the Solution-Focused Cognitive and Systemic Therapy (SFCST) process. By examining interview transcripts from clients receiving individual solution-focused therapy, researchers can identify recurring patterns and themes that emerge from the data. This qualitative research method will not only allow for the exploration of clients' perceptions of the helpfulness of various aspects of the SFCST process but also enable the investigation of how these perceptions are influenced by the level of engagement within the client-practitioner relationship.

Levels of engagement in the Bruges model of SFCST.

Four questions were developed to help define the level of engagement of the client and practitioner relationship. The level of engagement in the therapeutic relationship is not seen as a state or position of the client but as a relationship between the client and practitioner in which the client can become the expert of their own therapy. This so-called Bruges flowchart (*Solution-Focused Cognitive and Systemic Therapy*, n.d.) aims to help practitioners tailor their possible interventions to clients.

1. Is the goal of the client realistic?

   YES: Problem

   NO: Limitation

2. Does the client request our help?

   YES: Proceed to Question 3.

   NO: Uncommitted relationship

3. Is the request for help workable?

YES: Proceed to Question 4.

NO: Searching relationship, three types:

- Too little or too much information;
- "It's stronger than myself";
- "Someone else has to change."

4. Does the client know how to use the resources that are necessary to reach their goal?

NO: Consulting relationship

YES: Expert relationship.

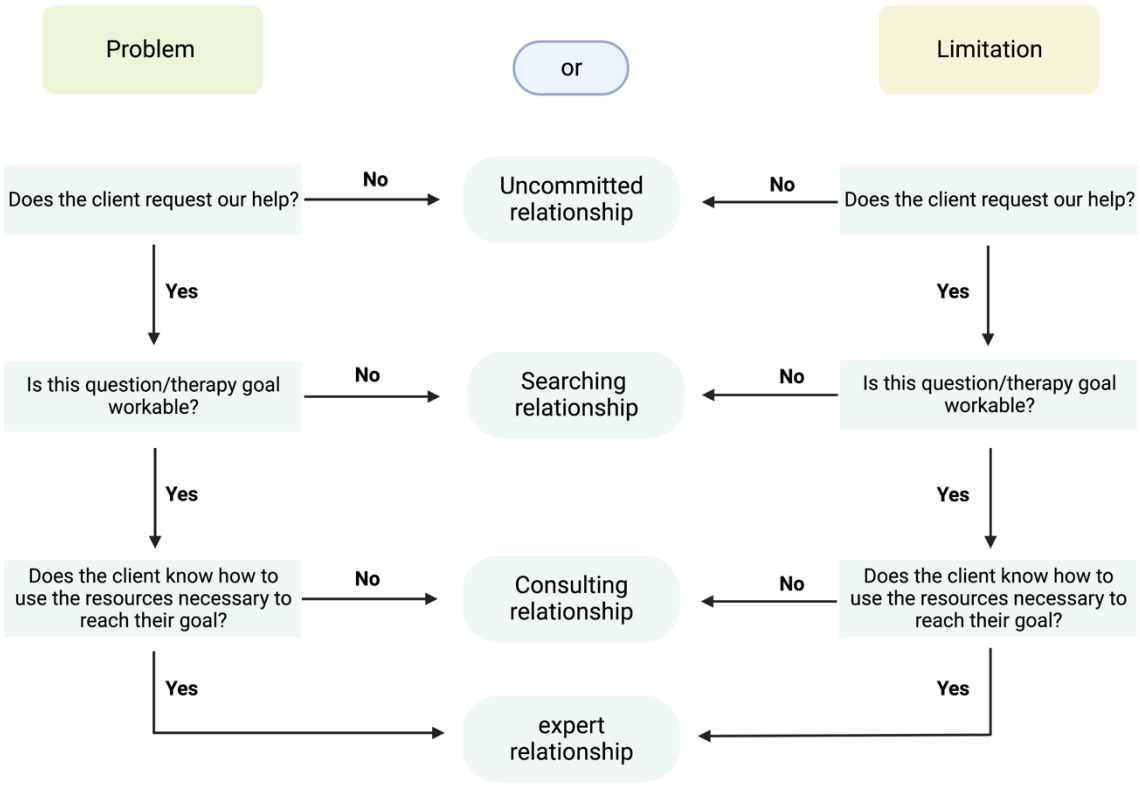


Figure 1: The Bruges flowchart

It is important to state that within the SFCST model, every client is seen as someone ready to work even in an uncommitted relationship. All clients possess motivation toward certain goals, and it

is the responsibility of the therapist to discover and identify their specific motivations. In solution-focused therapy, “we always work with motivated clients.”

This view of the practitioner-client relationship has evolved from the Brief Family Therapy Center (BFTC) model. In the original Milwaukee model, three types of clients were described based on the client's attitude towards the problem (De Shazer, 1988; Visser, 2013): Visitor, Complainant, and Customer. Visitor - when clients find that they have no issues themselves but attend therapy due to someone else's request, they have no clear idea about what they want from therapy; Complainant - when clients acknowledge a problem but anticipate others to resolve it, either because they don't see their role in creating change or are unable to take action; and Customer - when clients demonstrate a willingness to address their problem and are prepared to transition from talking to action.

These original categories were later adapted and simplified into a four-question flowchart by the staff at the Korzybski Institute in Bruges. Upon invitation from Steve de Shazer, the Bruges team presented their revised flowchart at the "Therapeutic Conversations III conference" in Denver, Colorado in 1996. De Shazer named it the 'Bruges flowchart'. Over time, this Bruges flowchart evolved and adopted a more systemic perspective of the therapeutic relationship, eventually developing in the model depicted above. More emphasis has been put on the description of the relationship between the client and therapist approaching the level of engagement from a systemic perspective and moving away from only describing the client’s position. In addition more neutral terms (“uncommitted” instead of “visitor”, “searching” instead of “complainant” and “consulting” instead of “customer”) are used to describe this level.

Aims and research objectives.

In this project, our primary goal is to utilize thematic analysis, a qualitative research method known for its effectiveness in identifying, analyzing, and reporting patterns or themes within a dataset. This method's flexibility and broad applicability make it suitable for various research contexts, including the study of psychotherapy processes. By examining recurrent patterns and themes across interview transcripts, researchers can glean insights into shared experiences, beliefs, and attitudes among participants.

We want to gain a deeper understanding of the specific elements of the Solution-Focused Cognitive and Systemic Therapy (SFCST) process that clients perceive as most beneficial and helpful. Additionally, it is crucial to explore how these perceptions may vary based on the level of

engagement within the client-practitioner relationship. This research protocol aims to investigate clients' perceptions of the helpfulness of various aspects of the SFCST process and how these perceptions change based on their level of engagement. The study's primary objectives are to replicate the SFCST model through an analysis of patient feedback and determine how the perceived helpfulness of specific elements shifts according to the client's level of engagement. The study protocol presented here draws on the research conducted by Andreea Żak (Mihaela, 2022) in Poland. Ms. Żak was consulted in the development of this research protocol.

To achieve these objectives, the study will be conducted in a natural setting with adult clients receiving individual solution-focused therapy in private practice. The research will involve multiple solution-focused practitioners who have obtained their SFCST psychotherapy degrees at the Korzybski Institute in Belgium. The data collection process will encompass demographic information on clients and therapists and qualitative feedback from clients on the most helpful aspects of their therapy sessions.

The data analysis will employ a combination of descriptive statistics, thematic analysis, and mixed-method approaches to identify patterns and relationships between variables. This comprehensive analysis will offer insights into the dynamics of the SFCST process, contributing to a more profound understanding of the factors that lead to successful therapeutic outcomes.

Aims:

This study aims to examine which components of the solution-focused cognitive and systemic therapy (SFCST) process clients perceive as beneficial and helpful and how their perception of these elements varies based on their level of engagement.

Objectives:

- To replicate the SFCST model through an analysis of the patient's feedback.
- To determine how the perceived helpfulness of specific elements changes according to the client's level of engagement.

The empirical study of this can complement the observations made by clinicians and theoreticians and reinforce their validity. Additionally, gaining an understanding of which elements are most effective at different stages of a client's engagement can allow practitioners to respect the client's individual pace in the therapeutic process.

Study design

Methodology

Data collection

Both qualitative and quantitative data will be collected. The qualitative data will be collected by the solution-focused practitioner asking the client a standard question at the end of a session: “What from what happened here today was most helpful for you?”. Translated into Dutch: “Wat in dit gesprek vandaag, vond je het meest zinvol of behulpzaam?”. The practitioner will directly transcribe this answer. No in-depth investigation will be used to extrapolate more meaning since the practitioner's knowledge of the SFCST model may influence the client’s responses. Asking this question can serve to obtain feedback from the client about the session. It can complement other routine outcome monitoring done by the practitioner. Outcome monitoring has been put forward to enhance therapy outcome (Lambert et al., 2003) and is recommended within the Bruges model.

The practitioner leading the session uses the Bruges flowchart to determine and record the client's level of engagement. We will gather demographic information on the clients, including their age, gender, ethnicity, and number of therapeutic sessions attended. Additionally, we will collect information on the therapists, including their age, gender, race, and years of clinical experience.

Data analysis.

Descriptive statistics.

We will use ANOVA to compare the client’s age and therapist's years of experience by level of engagement. Similarly, for comparing the distribution of gender, ethnicity, and number of sessions by level of engagement, we will use a Chi-squared test.

The sessions will be categorized into three categories: one, two to four, and more than four. A chi-square test will examine the association between participants' level of engagement and the number of therapy sessions. Post-hoc analyses with odds ratios and z-tests will be used to identify specific differences between the engagement levels across the session categories.

Thematic analysis.

Thematic analysis, a qualitative research method (Guest et al., 2011), will be employed to analyze the data. This technique involves identifying patterns, themes, and concepts within the qualitative data and organizing them into meaningful categories. In this study, the research team

uses thematic analysis to identify aspects the clients found helpful during therapy. The process of thematic analysis is typically carried out in a series of stages.

The first stage involves data familiarization, in which the researchers review and become familiar with the data collected from the participants. This allowes the researchers to identify patterns and themes that emerge from the data.

The next stage will involve coding the data by identifying and labeling data segments related to a specific theme or category. A coding framework will be developed and continuously refined to ensure that all relevant information is captured. The codes and categories will be labeled using the participants' language to ensure accuracy and authenticity.

The third stage will involve developing themes, which is the process of organizing the codes and categories into broader themes that capture the essence of the data. We will create the themes inductively, meaning they will be derived directly from the data without preconceived notions or assumptions. The themes will only be finally named in line with current terminology to show a relation while not influencing the coding process. Finally, the themes will be analyzed to identify any relationships between them and to draw conclusions from the data.

Finally, the themes identified in the first stage of the study will be quantified. This involves counting the number of times each theme was identified by participants to determine which elements of the SFCST process are more frequently perceived as helpful. A mixed-method approach will be used to analyze the data in the final analysis stage. Odds ratios will be computed to identify how the themes are connected to the quantitative data represented by the level of relationship.

Participants and procedure

We aim to conduct the research in a natural setting, where we will collect data from adult clients receiving individual solution-focused therapy in private practice. We plan to involve multiple solution-focused practitioners in the study who have obtained their SFCST psychotherapy degrees at the Korzybski Institute in Belgium. The recruitment of participants will continue until we reach theoretical data saturation.

Earlier results

As previously described, Andreea Żak has executed this protocol in a naturalistic setting in Poland (Mihaela, 2022). Following thematic analysis, the study identified eleven main themes, including one theme with categories of low frequency that did not fit into other themes (see Figure 2). Two themes contained psychotherapeutic elements not specific to the SFCST model, which the author has labeled as “generic” or common themes (theme 10 and theme 11).

The following themes were identified (themes and quotes are from (Mihaela, 2022)):

1. **Aim**: Clients found it helpful to co-construct therapy goals and define clear aims, knowing what they need and looking at the different options/choices they have in life. Visualizing a preferred future and understanding their agency in creating change were also put forward.

   Bruges SFCST model: The therapist's role is not to eliminate the client's symptoms. Instead, every form of therapy is considered self-therapy, as individuals can only change themselves. The therapist's responsibility is to establish a context that encourages and promotes freedom of choice by co-constructing therapy goals. The visualization of a preferred, desirable future functions as a potent catalyst for a self-fulfilling prophecy, guiding the client toward change.

2. **Exceptions**: Clients valued focusing on what works in their lives, analyzing exceptions to problems instead of focusing on what potentially caused them. Scaling questions helped clients see progress.

   Bruges SFCST model: The therapist wants to explore alternative habits. How is the client currently approaching the situation where the symptoms typically occur? Occasionally clients are often unable to recognize these exceptions due to their intense focus on their problems, and it is the therapist's task to help clients differentiate. Change is inevitable, with the SFSCT model we empower our clients in the direction of their desired change.

3. **Progress**: Clients appreciated discussing improvements between sessions and identifying what has already changed or is moving in the right direction.

Bruges SFCST model: “Staying with what works”, “once you find out what works, do more of it”. The therapist will try to highlight moments of success, focusing on ‘how’ they succeeded.

4. **Empowerment**: Clients found it helpful to recognize their strengths and resources, receive confirmation that they are on the right path, and receive compliments from the therapist.

   Bruges SFCST model: client empowerment is crucial in helping clients to discover their own skills and resources. Compliments, especially indirect ones, can play a role in facilitating this discovery process. Indirect compliments serve to provoke clients' thoughts about their capabilities and resources. In responding to these subtleties, clients essentially compliment themselves. Direct compliments, on the other hand, can be patronizing, as the therapist decides what is good for the client. In a similar way, ‘symptoms’ are seen as the best solution the client has now (Milton Erickson). This valorizes the effort of the client and normalizes symptoms. When asking “what do you want instead?”, you unintentionally disqualify the effort of the client.

5. **Action**: Clients valued the focus on concrete actions to reach their goals, including setting an action plan, having a clear direction, and identifying the first or next steps.

   Bruges SFCST model: after exploring the client’s existential choices and co-constructing therapy goals, the therapist guides the client in finding resources and skills in themselves to help accomplish these. The therapist helps in formulating therapy goals in a way that they are workable. While it's not impossible to stop undesired habits altogether, it generally presents greater challenges. Habits tend to arise automatically within their appropriate contexts. If clients clearly understand what they desire to do instead of what they wish to avoid, they can actively engage in those desired actions rather than attempting to do nothing.

6. **Central Philosophy**: when the client’s answers’ referred to the solution-focused triad:
   - If it isn’t broken, don’t fix it.
   - Once you find out what works, do more of it.
   - If it doesn’t work, do something different. Which was the most frequently mentioned element.

7. **Hope and Readiness to Change**: Clients felt hopeful about their situation improving and motivated to take action. (i.e., "*I can't wait to try this new idea out. I will create a stressful situation just to be able to try it*" (female client, 23 years old)").

8. **End-of-Session Feedback**: Clients found the therapist's summarization and suggestions at the end of sessions helpful.

Bruges SFCST model: therapists are encouraged to use client feedback measures to improve their outcomes. Based on the common-factors approach, the therapist wants to evaluate if the delivered therapy approach is a good fit with the client, enhancing the therapeutic alliance. This involves identifying clients who are not responding to therapy and approaching the lack of progress in a positive and proactive way. This approach helps actively explore new directions together. Examples of client feedback measures are the session rating scale (SRS) and outcome rating scale (ORS) developed by Barry Duncan(Hafkenscheid et al., 2010).

9. **Therapist's SF Attitude**: Some clients appreciated the therapist's non-judgmental, curious, and positive attitude without analysis of the past. Clients appreciated being heard and understood (i.e., ""*For me, it was helpful that you encouraged me to think without giving advice to 'do this or that', because this is a difficult situation in which I am in*" (female client, 37 years old)).

10. **Talking Things Out**: Clients valued the opportunity to express their thoughts and feelings, often resulting in immediate relief. This was the most frequently appreciated element of the session (i.e., "*I feel a bit better now because I was able to talk things out*" (female client, 35 years old)).

11. **Awareness and Understanding**: Clients appreciated gaining self-awareness, understanding their situation better, and reflecting on their experiences through difficult questions (i.e., "*You gave me difficult questions which irritated me but also forced me to think. I've never received such difficult questions, but they open my eyes to things I was not able to see before*" (female client, 20 years old)).
This theme had the second-highest frequency.

What Clients Perceived as Helpful from the Therapeutic Process (N = 346)

Themes and categories (subcategories)	Frequency, n(%)
SFBT-specific themes	
Theme 1: Aim	**54 (15.61%)**
Defining what they want	27 (7.80%)
- clear definition of the aim	17 (4.91%)
- knowing what they need	7 (2.02%)
- analyzing differences in options	4 (1.16%)
Future-talk	18 (5.20%)
Attitude towards change	13 (3.76%)
- starts with them	7 (2.02%)
- easy	5 (1.45%)
- realistic	2 (0.58%)
Theme 2: Exceptions	**21 (6.07%)**
Focus on what already works	9 (2.60%)
Analyzing exceptions (the how)	7 (2.02%)
Awareness is not that bad	6 (1.73%)
Theme 3: Progress	**38 (10.98%)**
Seeing change	25 (7.23%)
Going in the right direction	11 (3.18%)
Reaching the aim	4 (1.16%)
Theme 4: Empowerment	**34 (9.83%)**
Awareness of personal strength	15(4.35%)
Confirmation of doing the right thing	11 (3.18%)
Complements	11 (3.18%)
Theme 5: Action	**49 (14.17%)**
Knowing what to do next	26 (7.51%)
Having a plan	12 (3.47%)
Having a direction	6 (1.73%)
Setting small steps	9 (2.60%)
- importance of small steps	5 (1.45%)
- setting first/next step	4 (1.16%)
Theme 6: Central philosophy	**37 (10.69%)**
Change what doesn't work	24 (6.94%)
- do something different	12 (3.47%)
- awareness of what is not helpful	8 (2.31%)
- differentiation between what is and is not helpful	4 (1.16%)
Do more of what works	9 (2.60%)
- repeat what already works	6 (1.73%)
- generalize what works	3 (0.87%)
If it isn't broken, don't fix it	4 (1.16%)
Theme 7: Hope and readiness to change	**29 (8.38%)**
Feeling hopeful	22 (6.36%)
Feeling motivated to act	9 (2.60%)
Theme 8: End-of-session feedback	**30 (8.67%)**
Suggestions	26 (7.51%)
Summarization	5 (1.45%)

Theme 9: Therapist's SF attitude	**18 (5.20%)**
Being listened to and understood	7 (2.02%)
Non judgmental	3 (0.87%)
Not giving advice	2 (0.58%)
Directedness	2 (0.58%)
Curiosity	2 (0.58%)
Positivity	2 (0.58%)
Faith in the client	1 (0.29%)
Not analyzing the past	1 (0.29%)
Generic themes	
Theme 10: Talking things out	**87 (25.14%)**
Talking it out	82 (23.70%)
Feeling better	10 (2.89%)
Theme 11: Awareness and understanding	**83 (23.99%)**
About self	31 (8.96%)
- understanding oneself better	15 (4.34%)
- being normal	5 (1.45%)
- not being at fault	3 (0.87%)
- awareness of personal rights	2 (0.58%)
- realizing own limited influence	6 (1.73%)
About the situation	30 (8.67%)
- having a better understanding	18 (5.20%)
- having a different perspective	12 (3.47%)
Reflecting	23 (6.65%)
- by receiving questions	20 (5.78%)
- putting thoughts in order	3 (0.87%)
Theme 12: Other aspects	**6 (1.73%)**
Starting the therapy	2 (0.58%)
Don't know yet	2 (0.58%)
Nothing	2 (0.58%)

Figure 2: from (Mihaela, 2022)

Note. The total frequency of one theme is not equal to the identified categories, as one person may have mentioned several categories of the same theme, and thus was counted only once. Similarly, the total frequency of all themes is not equal to the number of participants, as one person may have mentioned several themes.

The two general themes, 'Talking things out' and 'Awareness and understanding', came up more often than any of the SFCST-specific themes. When looking at the SFCST -specific themes, the study found that 'Aim' and 'Action' was mentioned more often as helpful by clients. On the other hand, 'Exceptions' and 'Therapist's SF attitude' were less likely to be brought up by clients.

Almost all of the core elements of SFCST were identified as beneficial. However, pre-session change appears to be missing from the overall themes, which clients may find challenging to recognize and might not have been explored by the therapist. As expected in the context of the

common factor approach, clients also reported common factor themes that are not unique to the SFCST model. Interestingly, these generic elements were reported more frequently than those specific to SFCST. This finding aligns with the notion that the success of psychotherapy is influenced to a greater extent by common factors rather than specific model or technique factors (Lambert, 1986).

The relation between Themes and Level of Engagement

Additionally, the study looked at how the frequency of certain themes relates to the client's level of engagement. They used two models to categorize engagement levels: the Bruges and Milwaukee model (as mentioned earlier).

When applying the Milwaukee model, the study found that clients mentioned 'Aim', 'Progress', and 'Action' more often at the 'Customer' level than at the 'Complainant' and 'Visitors' levels. Interestingly, the theme 'Talking things out' was mentioned more often by 'Complainants' than 'Customers,' suggesting that clients might find it more helpful to just talk about their issues at a lower level of engagement. There was no significant difference found between 'Complainants' and 'Visitors' in terms of this theme.

When considering the Bruges model, 'Aim', 'Progress', and 'Action' were mentioned more often by clients in a 'Consulting' relationship than an 'Uncommitted' relationship. 'Progress' and 'Action' were also mentioned more often in the 'Consulting' than the 'Searching' relationship, suggesting these themes become more important as the level of engagement increases. The 'Talking things out' theme was more often mentioned in the 'Uncommitted' or 'Searching' relationship than 'Consulting' relationship, and more often in the 'Uncommitted' than 'Searching' relationship. This again suggests that clients might find talking things out more helpful at a lower level of engagement. No significant differences were found for the 'Expert' level in the Bruges model, likely because there weren't many clients in this group.

In summary, this study reveals that clients' level of engagement in therapy can impact the frequency of specific themes they mention. Additionally, therapists utilizing the SFCST model assess the level of engagement through the flowchart, which in turn influences the types of questions asked and subsequently affects the potential themes that emerge from clients' responses. At a higher level of engagement, clients tend to find discussing goals, progress, and actions more helpful, while at a lower level of engagement, clients find talking things out more helpful. The relative importance of different aspects of the therapeutic process, as determined by the client's level of engagement, suggests that the type of questions the therapist asks should take into account the

level of engagement as implied by the SFCST model. These insights emphasize the importance of the Bruges flowchart as a potent tool for assessing client engagement levels in therapy. The study also reaffirms the utility of this tool in customizing therapeutic strategies to synchronize with clients' engagement levels, thereby enhancing the efficacy and outcomes of the therapeutic process.

Study limitations

The importance of therapeutic elements may vary depending on the specific characteristics of the sample. Clients who voluntarily seek psychotherapy in private practice might be more inclined to value interventions focused on aim and action. To enhance generalizability, future research on this topic could involve a broader range of psychotherapists and the recruitment of clients from diverse settings. It would also be valuable to conduct studies in different cultural contexts and with diverse populations to explore whether the perceived helpfulness differs across cultures. In addition to the already substantial body of literature consisting of articles, publications, meta-analyses, reviews, and outcome studies on solution-focused work.

Conclusion

To summarize, this research project aims to contribute to the growing body of knowledge on the SFCST approach by exploring clients' perceptions of its beneficial elements and how these perceptions vary based on the level of engagement within the client-practitioner relationship.

It is important to acknowledge the invaluable contributions of pioneers and innovators in the field of SFCST, specifically Dr. Luc Isebaert and his colleagues at the Korzybski Institute. Their groundbreaking work and dedication have laid the foundation of this therapeutic approach. The true credit belongs to these esteemed pioneers and innovators, whose contributions have paved the way for further exploration and understanding of the SFCST model. Additionally, I want to express my appreciation to Andrea Żak, whose study forms the foundation of this research proposal. With her consent, we have drawn inspiration and built upon her valuable insights. Finally, I thank Kathleen Defoort for bringing up the idea and facilitating the connection with Andrea Żak.

We look forward to conducting this research in the forthcoming future and disseminating our findings, to spark a greater degree of interest and respect for the SFCST approach within the scientific community. We hope to contribute modestly to this approach's ongoing growth and development.

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