# Microanalysis on the use of time in cognitive behavioural therapy versus the solution focused approach.

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## Abstract

Cognitive behavioural therapy (CBT) and the solution focused approach (SFA) have different assumptions, respectively; problem-solving versus solution-building. This study tried to discover if this theoretical difference implies a difference in practice. To be more specific; CBT sessions should include more talk about the client's past, when/why does the problem occur? Whereas SFA sessions should focus more on the future live of the client, including the client's ideal future and his/her goals. This study used microanalysis to test whether the practice reflects these hypotheses. The study accomplished a high inter-analyst reliability. The results demonstrated differences within the SFA-group on the use of past-, present- and future-tensed verbs. The results showed differences within the CBT-group on the use of past- and future-tensed verbs. Between the CBT- and SFA-group, differences were found on the use of present- and future-tensed verbs. Besides that, there was no evidence that the client responded the therapist in the same time-focus.


Keywords: Solution focused, Cognitive Behavioural, Microanalysis, Communication, Therapy.

## Introduction

The founder of the solution focused approach, De Shazer, called the development of the solution focused approach a 'paradigm shift'; this strategy breaks with all the standards of psychotherapy. Before some therapists started using the solution focused approach, psychotherapy was fixated on retrieving and analyzing the cause of the problem. The solution focused approach however, applies a different philosophy; the client's strengths -instead of the client's problems- play a central role in therapy (Trepper, Dolan, McCollum, & Nelson, 2006).

In the 1980s the solution focused approach (SFA) emerged in the Brief Family Therapy Center in Milwaukee. De Shazer and co-founder Kim Berg were inspired by the findings of Watzlawick, Weakland and Fisch (1974) and the theory of Milton Erickson. Watzlawick et al. (1974) believed that, in some conditions, attempts of solving the primary problem can result in the appearance of new problems. In other words; preconceived solutions can cause maintaining or deterioration of the problem. Watzlawick et al. (1974) illustrated this assumption with the following example. Everyone has experienced a night when you cannot fall asleep. One will try to force oneself into falling asleep. But falling asleep is a spontaneous phenomenon, which one cannot enforce oneself to do. Next, one will be imprisoned by a vicious circle; time is passing by and one is trying harder to fall asleep. The solution is making the person more desperate than the problem itself. These false solutions could lead to irrational habits and believes. Watzlawick et al. (1974) also believed that an insight in the cause and origin of the problem is not necessary if one is trying to find a solution.

The theory of Milton Erickson was the second influence which led to the foundation of the solution focused approach. Erickson believed that people have the instinctive desire for

personal growth and therefore have the power to change themselves. Moreover, Erickson assumed that the client was more willing to cooperate in therapy if the therapist pointed out the client's positive behaviours (Haley, 1973). So he emphasized the situations in which the client showed doing something (different). Erickson made sure that the client's competency played a central role in therapeutic sessions (Lewis & Osborn, 2004).

Both Erickson and Watzlawick had a (social) constructivist mindset. The constructivist philosophy assumes that our understanding of the world is constructed by our own experiences and our reflections of those experiences. We make our decisions based on this construction. This construction is however changeable. If we encounter a new event, we can choose to change our previous believes or qualify this new information as meaningless (Mahoney, 2003). In terms of social constructivism this means that one makes a construction about his/her believes based on communication with others. Therefore, language is important in the perspective of social constructivism. A conversation could change one's ideas about his/her problems and could give insight in optional solutions (Bannink, 2006). The perspective of social constructivism has lead to an important assumption in the solution focused approach. This assumption includes that people change in therapy because of communication. The second assumption of the solution focused approach is that the client is considered to be the expert of the problem. He/she is the only one who exactly knows what he/she feels. The client is also the only one who could come up with the best solution for the problem. After all, he/she knows what works best for him/her (Walter & Peller, 1992). The final assumption is that people have strengths, besides their weaknesses. The achievements of the client play a central role in the therapy sessions (Bannink, 2006). These three assumptions make clear that co-construction is very important in therapy: the therapist has to work with, instead of for, the client (Lewis & Osborn, 2004).

In current psychotherapy, cognitive behavioural therapy (CBT) is a method that helps clients to understand the thoughts and feelings that influence their behaviours. A wide range of disorders and problems can be treated with cognitive behavioural therapy. Since the efficacy of cognitive behavioural therapy is confirmed by many evidence based studies, Cognitive behavioural therapy is a very influential method in psychotherapy now days. Cognitive behavioural therapy is a mixture of cognitive therapy and behavioural therapy.

Founding fathers Beck and Ellis started developing cognitive therapy in the sixties. The basic assumption of this therapy is that thoughts, feelings and behaviour influence each other. A negative thought leads to a negative emotion, which leads to negative behaviour. These negative thoughts are often irrational and not based on the truth. Such an irrational thought often maintains or even strengthens a negative self-image. So in order to change the behaviour, it must be clear which negative emotion(s) and thought(s) lie(s) underneath the particular behaviour. Cognitive therapy is based on gaining insight into unconscious emotions and motivations (Jacobs, Muller, & Ten Brink, 2001).

Behavioural therapy tries to understand why the client displays a specific kind of behaviour. Behavioural therapists try to eliminate or change the stimulus which has an influence on the particular behaviour. They achieve this change by giving rewards if there is an improvement in the behaviour. By giving rewards, instead of punishment if the desired behaviour is not present, the therapist makes it clear to the client what he or she should do, instead of what he or she should not do. This kind of reinforcement is called operant conditioning (Verheij & Verhulst, 1996).

Cognitive behavioural therapy is based on the assumption that irrational thoughts lead to dysfunctional behaviour. Cognitive behavioural therapists try to change the content of these

irrational thoughts; they try to turn these into ‘helping thoughts’. Techniques from behavioural therapy are used to change these negative thoughts. An important instrument in cognitive behavioural therapy is therefore the ABC-model. The ABC-model helps to clarify the context of the circumstances. The ‘A’ stands for ‘activating event’. This includes the event that leads to the inadequate feelings and behaviour. For example, the client has some disappointing grades on his school report. This event leads directly to ‘B’; the belief system. This system is a thinking process which takes place between ‘A’ and ‘C’. Our belief system influences our point of view. In the example as described above, the irrational thought could be: ‘I always have to perform well.’ This thought leads to ‘C’; consequences. The irrational thoughts give rise to irrational feelings and behaviour. In this example, it could lead to brooding, loss of energy, school refusal and feelings of sadness. This model gives insight into the client’s belief system. The client will discover which irrational thought leads to negative feelings and behaviour. To start the intervention, the DEG-model is used. The intervention starts with (‘D’) challenging the irrational thoughts. Subsequently the client must be willing to actively use this new knowledge by practising new, rational thinking (‘E’) and the new behaviour (‘G’). The DEG-model applied to the example, would lead to the following. First, the therapist would challenge the irrational thoughts of the client: ‘What would you say to your best friend if he told you that he always has to perform very well?’ This kind of exercise will lead to an evolution of new, rational thoughts: ‘It is impossible to perform well all of the time.’ This thought helps to set the activating event in perspective and will lead to different emotions (cheerful) and behaviour (going back to school) (Jacobs, 2008).

Because of the fact that the solution focused approach is founded in practice and is only briefly studied by academic research, it is not easy to assign this approach to a specific, existing form of therapy. It is still a discussion whether the solution focused approach can been ranged within an existing therapy or can be seen as an independent, new kind of psychotherapy. The solution focused approach can be seen through a lot of different perspectives. It is sometimes called 'Carl Rogers with a twist', because of the empathic attitude of the therapist. Another agreement between the solution focused approach and client centered therapy is the fact that the client is considered to be the expert of the problem. The therapist has a guiding role during the sessions (Cepeda & Davenport, 2006). Cepeda and Davenport (2006) are suggesting integrating the solution focused approach and client centered therapy. They believe that the solution focused strategy could be applied in client centered therapy if the client is motivated enough to work on his/her future goal.

Bannink (2006) sees the solution focused approach as a shade of cognitive behavioural therapy. To motivate this assumption, she has the following six arguments. First Bannink recalls the definition of behavioural therapy: using the methods and findings which experimental psychology has obtained. These findings include the theory of Pavlov (classic conditioning) and Skinner (operant conditioning). Both cognitive behavioural therapy and the solution focused approach are applying these two theories. During a session according to the solution focused approach, the therapist even importunately points out the positive things. This works the same for withholding attention to the problem. Bannink's second argument is that they both cognitive behavioural therapy and the solution focused approach try to achieve the same goal: helping the client making the wanted changes. The third argument is that both cognitive behavioural therapy and the solution focused approach do not focus on the emotional side according to Bannink. Both

methods accept the impact of emotions and try to validate them, but emotions do not take the leading role in these approaches. The focus of both cognitive behavioural therapy and the solution focused approach is on thoughts and behaviours. The common goal is to change the view on the problem (cognition) and to change the occurrence of the problem and the client's reaction on it (behaviour). Bannink's fourth argument is that the solution focused approach and cognitive behavioural therapy follow roughly the same therapeutic process (diagnostics, interventions, evaluation and completing the therapy). Fifth, solution focused therapists also make functional analyses, but with one difference; solution focused therapists make these analyses about exceptions (moments in which the desired behaviour is already happening). Cognitive behavioural therapists make these analyses about the problem. Bannink's final argument is that both cognitive behavioural therapy and the solution focused approach work with homework assignments and scaling questions (Bannink, 2006).

Besides these similarities, Smock, Froerer and Bavelas (2009) point out seven important differences between cognitive behavioural therapy and the solution focused approach. First, cognitive behavioural therapy proclaims that there are different forms of cognitive behavioural therapy. Cognitive behavioural therapy can be seen as an overarching term for more specialized shades of cognitive behavioural therapy, for example dialectical behaviour therapy and rational emotive behaviour therapy. The solution focused approach however, is a method which has clear and undisputed criteria. Because of these criteria it is assumed that therapists, who are following the solution focused approach, are more homogeneous than cognitive behavioural therapists. This means that cognitive behavioural therapists differ more from each other in what they are saying and how they are acting during their therapy sessions than solution focused therapists. The second difference includes the fact that cognitive behavioural therapists and therapists who

work with the solution focused approach have both a different view on clients. Cognitive behavioural therapists assume that clients suffer from a problem or deficiencies and need a therapist to help them change their thoughts and behaviours. The solution focused approach assumes that clients are fully equipped to change their own lives. This difference directly leads to the third difference: a different role for the therapists. In cognitive behavioural therapy the therapist will have a leading and expertise roll. The opposite can be found in the solution focused approach; the client is considered to be the expert and the therapist has a guiding roll, whose main function is to point out the client's strengths. The fourth difference claims that cognitive behavioural therapists and solution focused therapists aim to achieve different goals. In cognitive behavioural therapy changing the irrational thoughts into rational thinking is the main goal (Smock et al., 2009). The solution focused approach tries to trace the desired, ideal future of the client (De Jong & Berg, 2004). According to Smock et al. (2009) the fifth difference between the solution focused approach and cognitive behavioural therapy lies in their philosophy about communication. For cognitive behavioural therapists, communication is a tool to change the client's thoughts (Jacobs, 2008). As mentioned before, solution focused therapists are co-constructing ideas together with the client. The communication leads to new ideas in both the client and the therapist (Walter & Peller, 1992). The sixth difference can be found in basic assumptions of the two approaches. Cognitive behavioural therapy is based on the term 'problem-solving'. This reveals itself in practice by retrieving the specific problem and finding the best reaction for this situation (Jacobs, 2008). The solution focused approach on the other hand is based on the term 'solution-building'. In practice this means that the client en the therapist are brainstorming about possible solutions without knowing (all the details of) the problem (De Shazer, 1986). At last, according to Smock et al. (2009), one can find some subtle

differences between the two approaches by looking closer to the sessions. Both techniques work with scaling questions. Whereas cognitive behavioural therapists ask their clients to rate *how bad* an experience *was*, solution focused therapists refer in their scaling questions to positive experiences and feelings and besides that, they often ask about raising the grade in the future ('What need to happen that would change that 6 into a 7?'). An important side note is the fact that the solution focused scaling questions are all credited with a positive label, the score '0' on a scale of 0 to 10 does not have the definition 'bad', but 'the most far away from the ideal future'. Coherent with this assumption, is the following difference: the scaling choices in the solution focused approach are idiographic. This means that each grade has a personal meaning for the client. The client can attribute his/her own value to a score. Whereas in cognitive behavioural therapy the labels of each number a universal, for example: '5' is neutral on a scale from 1 to 10. These subtle differences can also be seen in homework assignments and in the construction of therapy goals (Smock et al., 2009).

Goijaarts and Laros (2010) found four elements which can be credited as the basics of the undisputed, clear criteria which Smock et al. (2009) mentioned. If those elements would be confirmed by research, these results would provide more evidence for the hypothesis that the solution focused approach is an independent kind of therapy.

The first element includes the shifting of perspectives. According to Gooijaarts and Laros (2010), solution focused therapists switch a lot between different perspectives in the conversation. For example, the therapist asks what the client's mother/teacher/partner would say. This technique is used to make the client think without boundaries. Whether this element is typical for the solution focused therapy stays rather questionable. Since this technique is often

used by cognitive behavioural therapists to challenge the irrational thoughts of the client. For example, a therapist could ask a client who is suffering from fear of failure: 'What would you say to your best friend if he told you that he always has to perform very well?'

According to Gooijaarts and Laros (2010), the second element contains the use of specificity. The therapist and the client achieve more concrete examples during probes. Using these examples the therapist provides more insight into what is happening when the problem does not occur. During which situations, characteristics or ideas is the problem not present (N. Laros, Ouwens, P.C.M. Laros, & Bavelas, 2010)? Again, it is also questionable if this element is typical for solution focused therapists. In cognitive behavioural therapy situations which the client tells about are going to be explored. This is necessary for cognitive behavioural therapy, since they are working with the ABC- and DEG-model. Cognitive behavioural therapists specify a situation to make clear which irrational thought lies underneath the displayed behaviour. The difference between the solution focused approach and cognitive behavioural therapy on the element 'specificity' would lie in the subject of what they are going to explore. Solution focused therapists are exploring exceptions; when does the problem not occur? Cognitive behavioural therapists are exploring the situation in which the problem does occur.

Gooijaarts and Laros (2010) claim that the third element of solution focused therapy is the positive tone of the therapist. The solution focused therapist uses more compliments and would only reflect on the positive behaviour of the client. This element is based on Erickson's idea that the positive tone of the therapist would increase the motivation of the client. This element is studied by Tomori and Bavelas (2007). They examined the differences between solution focused sessions and client centered sessions on the content of the therapist's formulations. Using videotaped sessions and matching transcripts, this study found a significant

difference in the use of positive and negative contents of the therapist's formulations. This study concluded that the solution focused approach used more positive formulations than client centered therapy. Smock et al. (2009) examined the differences between the solution focused approach and cognitive behavioural therapy on the use of positive and negative formulations. Smock et al. (2009) found that the solution focused therapists use more positive formulations than the cognitive behavioural therapists.

According to Gooijaarts and Laros (2010), the last element is that the solution focused therapist's formulations are future-focused. This element is based on the Erickson's idea that everybody has a personal desire for growth and change. Therefore solution focused therapists do not focus on the problem, but on how the client has to change to achieve his/her ideal goals. A special technique, which is only used by solution focused therapists, is the miracle question: 'What if you wake up tomorrow and a miracle has happened?'(De Jong & Berg, 2004). This element is studied by N. Laros et al. (2010). They examined the differences between solution focused sessions and client centered sessions on use of verb-tenses of the therapist. Using videotaped sessions and matching transcripts, this study found a significant difference in on use of past-, present- and future-tensed verbs. The analysis displayed a significant difference between the use of past- and future-focused formulations. This study concluded that the solution focused approach uses more future-focused formulations than past-focused formulations in comparison to client centered therapy (N. Laros et al., 2010).

This current study attempts to contribute at the hypothesis which assumes that the solution focused approach is an independent, different kind of therapy. The element of future-focused formulations is the subject of this study. In addition to the study of N. Laros et al. (2010),

this study examined the use of time in both the therapists' and the clients' formulations. Furthermore, this study will compare the solution focused approach with cognitive behavioural therapy. Therefore this study worked with three sessions by solution focused approach (SFA) experts and three sessions by cognitive behavioural therapy (CBT) experts. Furthermore, this study wanted to research the link between two element that were described by Gooijaarts and Laros (2010), which are the following two; the use of time and type of content. This study had the privilege to work with the results of the earlier study on type of content by Smock et al. (2009). Therefore this present study has analysed the same video sessions which were used in the study of Smock et al. (2009), so the two dataset could be compared with each other.

This study conducted the following research questions: (1) Are there differences within the SFA-group on the use of time? (2) Are there differences within the CBT-group on the use of time? (3) Are there differences between the SFA-group and CBT-group on the use of time? (4) Is there a connection between the use of time of the therapist and the use of time of the client? (5) Is there a connection between the use of time and the positive or negative content of the utterance?

## Method

### Microanalysis

Communication plays an important role in everyday life. In psychotherapy, communication fulfils a central function; the therapist and client exchange information. During this exchange of information the therapist and the client can develop ideas together (Bavelas, McGee, Phillips, & Routledge, 2000). The importance of communication in therapy is therefore

evident. To gain insight in how communication in therapy works, an examination of the sentences which were used during a therapeutic session is necessary (Bavelas, et al., 2000). Recently, communication became a subject of scientific research. Especially the fine details of interaction, such as non-verbal gestures, tone and choice of words, gain more interest in academic science. To study these details a distinctive research method is required. This method is called 'microanalysis'. Using videotapes or audio recordings and matching transcripts, microanalysis makes it possible to investigate details which would remain undiscovered otherwise (Bull, 2002). This current study will also perform a microanalysis to investigate the use of time in CBT- and SFA-sessions.

## Data

This study analyses six full-length video sessions, three sessions for each therapeutic approach. The same videos were used in the study of Smock et al. (2009), this makes it possible to search for a connection between the use of time and the type of content. Furthermore, the sessions meet the following three criteria. First, the therapist is considered to be an expert in the solution focused approach or cognitive behavioural therapy. All of the sessions were examples which were offered for training students in one of the two forms of therapy. Second, the videos were published and therefore available for the authors. Last, Smock et al. (2009) tried to match the solution focused and cognitive behavioural sessions. There are three female and three male therapists. In both of the groups there is one session which includes a suicide attempt. This last criterion makes it possible to make a more reliable comparison between the two groups. However, there are several important footnotes one has to observe. First, two of the solution focused sessions and one of the cognitive behavioural sessions worked with actors. The other three sessions include real clients, who gave permission to use the videos for scientific research

and educational needs. Obtaining these permissions of the clients is rather difficult. Therefore, the reconstructed sessions are more likely to be published for legal and ethical reasons. Studies that focus on the (re)actions of the client will encounter more difficulties when using videos which are replicated by actors. However, this study will predominantly focus on the therapists and therefore working with actors is more accepted. The experienced therapists in these videos want to demonstrate their theory and will probably react the same in a session with a real client (Smock et al., 2009). The second footnote includes the fact that all six clients are different individuals with different problems. Therefore the sessions do not match each other completely. Table 1 shows the inclusion criteria of the video sessions.

Table 1

*Inclusion Criteria*

| | Therapist | Therapist status | Client Status | Session Number | Presenting Problem | Full Session? |
|---|---|---|---|---|---|---|
| CBT | Lichtenberg | Expert | Actual Client | 1 | Problems Within Primary Supportgroup | Yes |
| | Meichenbaum | Expert/Founder | Actual Client | 1 | Depression, Anxious, Suidicide Attempts | Yes |
| | Persons | Expert | Actor | 4 | Social Fobia | Yes |
| SFA | Berg | Expert/Founder | Actual Client | 1 | Suicide Attempt | Yes |
| | De Shazer | Expert/Founder | Actor | 1 | Psychosis | Yes |
| | Dolan | Expert | Actor | 1 | Substance Abuse | Yes |

The therapists in the cognitive behavioural sessions were Peter Lichtenberg (American Psychological Association, 2006), Donald Meichenbaum (American Psychological Association,

2007), and Jacqueline Persons (American Psychological Association, 2006). The producers of each video provided the following background for each case.

Lichtenberg: "In this session, Dr. Lichtenberg works with a 78-year-old woman whose husband is ill, but is controlling. Because many of her friends have died or live elsewhere, the client has no support network to help with the stressors she faces. Dr. Lichtenberg works with her to help to define her problems and focus on what she can change" (paraphrased from APA, 2006).

Meichenbaum: "In this session, Dr. Meichenbaum works with a young woman who is depressed, and anxious, and has suicidal tendencies. She has undergone multiple traumas in her life, including rape and several suicides in her immediate family. Dr. Meichenbaum accentuates the client's strengths, skills, and support system. Then he gently confronts the client by helping her to see that, although one of her strengths is her willingness to forgive others, she has not been able to forgive herself for things she has done" (paraphrased from APA, 2007).

Persons: "In this session, Dr. Persons works with a 29-year-old woman who recently developed social phobia. Together they work to overcome her fears through the use of exposure exercises and strategies for making social interactions more manageable" (paraphrased from APA, 2006).

The solution focused group contains the following therapists: Insoo Kim Berg (Solution Focused Brief Therapy Association, 2008), Steve de Shazer (Solution Focused Brief Therapy Association, 2008), and Yvonne Dolan (Solution Focused Brief Therapy Association, 2008). The producers of each video provided the following background for each case.

Berg: "Insoo Kim Berg meets with a teen-aged boy living in a family with repeated violence who had attempted suicide the night before. Insoo carefully reviews with him the details

of his successful strategy that led to him "making it to school" the next morning. They turn this traumatic situation into a hopeful encounter based on his dreams for a better life" (paraphrased from Solution Focused Brief Therapy Association, 2008).

De Shazer: "The client complains of difficulty sleeping because her upstairs neighbour is beaming shock waves through the ceiling from his strange 'electrical machine' aimed at her bed. She reports that hospitalization and psychotherapy, including medication, not helped. De Shazer demonstrates the process of 'radical acceptance' of the client's view as a way to build a useful therapeutic relationship, to find exceptions, and how to use scaling questions" (paraphrased from Solution Focused Brief Therapy Association, 2008).

Dolan: "Yvonne Dolan interviews a young woman who is struggling with getting on with her life after her heart stopped after a drug overdose. This involves giving up her relationship with her abusive boyfriend while missing him and staying in touch with him. By following the woman carefully, Yvonne is able to skilfully guide the negotiation about what the client really wants" (paraphrased from Solution Focused Brief Therapy Association, 2008).

## Materials

The video sessions were analysed using the program ELAN, a free downloadable program which is available from the Max Planck Institute for Psycholinguistics. This program makes it easier to play and to rewind the videos. Moreover, it is possible for the user to make annotation layers and to add notes in the session, which will be displayed at the time in which they are made in the video.

The protocol for analysing the use of time is retrieved from a study of Laros, Ouwens, Laros and Bavelas (2010). Because of the requirements of this current study, this protocol is

updated and can be found in Appendix I. The protocol is supplemented with more explicit examples and a footnote. This footnote includes that it is always more important as a viewer to look at the context of the utterance and not just the literal verb tense.

The transcripts and the videos are obtained through Harry Korman, who is an active researcher on microanalysis and a solution focused clinician.

## Inter-rater reliability

For the purpose of demonstrating inter-rater reliability, this study worked with three independent analysts; Nikkie Laros, Peter Laros and Peggy Emmerink. Calculating the inter-rater reliability was required for two reasons. First, the analysts could verify if the other analysts were not drifting from the rules of the protocol. Second, if a high consensus was achieved, this would be evidence for the assumption that the protocol is an appropriate tool for detecting verb-tenses in psychological sessions. Nikkie Laros examined all of the data. Both Peter Laros and Peggy Emmerink examined approximately 50 utterances of each session. Depending on the session length, 50 utterances include an average of 18.7% of each session. The 50 utterances were chosen by Nikkie Laros and selected on their grade of difficulty. The passage which was experienced to be the hardest part of the session was chosen to be examined by the second en third analyst. Peggy Emmerink, who never worked with the protocol before, examined all six passages. Peter Laros, who has worked with the protocol before (Laros et al., 2010), examined three passages. The passages which were analysed by Peter Laros were two CBT-sessions (Lichtenberg and Persons) and one SFA-session (De Shazer). Peter Laros analysed one SFA-session, because he has experience with the protocol on SFA-sessions. Since Peter Laros was not familiar with the protocol on CBT-sessions, he has examined two sessions of the CBT-group.

These three sessions were chosen on their grade of difficulty, selected by Nikkie Laros and Peggy Emmerink. They considered the Lichtenberg-passage to be the most difficult session to analyse for the CBT-group and Persons to be the easiest session to analyse for the CBT-group. According to Nikkie Laros and Peggy Emmerink, the De Shazer-session was the most difficult session to analyse for the SFA-group.

The reliability is calculated in two steps according to the protocol as shown in Appendix I. Step 1 includes selecting all the used verbs in the session. The disagreements found in this first step were excluded from counting the reliability in step 2. This procedure is used to prevent the calculations from overlap. The inter-rater reliability can be seen in Table 2, Table 3 and Table 4.

Table 2

*The inter-reliability between Nikkie Laros and Peggy Emmerink.*

| | Groups | | | | | |
|---|---|---|---|---|---|---|
| | CBT | | | SFA | | |
| | Meichenbaum | Persons | Lichtenberg | De Shazer | Berg | Dolan |
| *Agreement Step 1* | 98.7 | 100 | 98.5 | 100 | 100 | 99 |
| *Agreement step 2* | 86.2 | 79.1 | 78.5 | 82.6 | 85.2 | 73.2 |

*Note*. The values represent percentages.

Table 3

*The inter-reliability between Nikkie Laros and Peter Laros.*

| | Groups | | |
|---|---|---|---|
| | CBT | | SFA |
| | Persons | Lichtenberg | De Shazer |
| *Agreement Step 1* | 93.6 | 92.3 | 94.6 |
| *Agreement step 2* | 77.7 | 81.5 | 71.3 |

*Note.* The values represent percentages.

Table 4

*The inter-reliability between Peggy Emmerink and Peter Laros.*

| | Groups | | |
|---|---|---|---|
| | CBT | | SFA |
| | Persons | Lichtenberg | De Shazer |
| *Agreement Step 1* | 93.6 | 93.8 | 94.6 |
| *Agreement step 2* | 78.6 | 73.8 | 71.3 |

*Note.* The values represent percentages.

For step 1, a few disagreements were due to simply overlooking some verbs. An agreement of 100% is not an exception. The lowest score can be found between Nikkie Laros and Peter Laros (Table 3) in the Lichtenberg-session; 92.3%. For step 2, the highest agreement is

achieved between Nikkie Laros and Peggy Emmerink (Table 2) in the Meichenbaum-session; 86.2%. The lowest agreement can be found in the De Shazer-session. Nikkie Laros and Peter Laros (Table 3) achieved an agreement of 71.3%. The same percentage can be found between Peggy Emmerink and Peter Laros (Table 4).

If the analysts could not agree, they solved their disagreement in a deliberation. If necessary, they recruited an independent analyst (Janet Bavelas), who helped creating the protocol, to come to a final conclusion. Eventually, this led to a full agreement between all the three analysts. These resolved decisions were used as the final data.

## Statistics

It was not possible to conduct an analysis of variance or a T-test on the research questions of this study, since these types of tests require the presence of a mean for deducting variances. This study only benefit from comparing frequencies, therefore the data of this study does not include any means. Finally, one cannot interpret the T-tests as if they are independent of each other. The reason is that these T-tests use proportions. These proportions must add up to 1.0, so if a past proportion is higher, something else must be lower. Therefore the chi-square test is selected to investigate the research questions of this study. A chi-square test of homogeneity was used to investigate the first three research questions. To investigate the fourth research question, a chi-square test of independence was used. The chi-square test was chosen, because the scope of the research questions is to see whether there is a significant difference between frequencies. The chi-square test of homogeneity was used in the first three research questions, because this test examines whether two populations have the same proportion of observations. The chi-square of

independence was used in the fourth research question, since this test measures whether the frequency of one variable helps to predict the frequency of the other variable.

The fifth research question, to find out whether there is a connection between the use of time and the positive or negative content of the utterance, could not be examined with a statistical analysis for the following reason. The two protocols, the one on time and the one on content, differ in their data selection. The protocol on time analyses each verb separately. The protocol on content analyses each utterance. Due to this difference it was not possible to connect the two datasets and conduct a statistical analysis. The following example will illustrate this problem.

Lichtenberg #7: "Let's goes through a little bit about that incident. You're talking about your husband, right? (C: um hmm) And you've been married how many years?"

According to Smock et al. (2009), this utterance was negative because of the first sentence. The other two sentences were neither positive nor negative ("neutral"), and in this analysis system (Appendix II), positive or negative always dominated over neither: "If the utterance had even one positive or negative phrase, the positive or negative content always took precedence over the neither rating". It would not be accurate to call all of Lichtenberg's verbs negative.

## Results

### Descriptive data

Table 5 shows the session lengths, number of utterances and the total amount of analysable verbs.

Table 5

*Descriptive data*

| | | Total length | Total utterances | Total verbs |
|---|---|---|---|---|
| CBT-group | Meichenbaum | 44 min, 59 s | 304 | 1244 |
| | Persons | 32 min, 47 s | 234 | 916 |
| | Lichtenberg | 45 min, 40 s | 627 | 1329 |
| SFA-group | De Shazer | 50 min, 37 s | 208 | 1216 |
| | Berg | 35 min, 35 s | 256 | 923 |
| | Dolan | 51 min, 30 s | 259 | 906 |
| Total | | 261 min, 8 s | 1888 | 6534 |

Statistical results

Table 6 shows the results on the following research question; are there differences within the SFA-group on the use of time?

Table 6

*Chi-square analysis on the use of time within the SFA-group (n = 3).*

| Tense | $\chi^2$ | *p* |
|---|---|---|
| Past | 8.22 | < .02 |
| Present | 7.90 | < .02 |
| Future | 53.59 | < .001 |

*Note.* *df* = 2 for all chi-squares.

A chi-square test of homogeneity was performed to examine the difference on the use of past-tensed verbs between the three SFA-therapists. The difference was significant, $\chi^2$ (2, $N$ = 260) = 8.22, $p < .02$. There was a significant difference on the use of past-tensed verbs between the SFA-therapists.

To examine the difference on the use of present-tensed verbs between the three SFA-therapists, a chi-square test of homogeneity was performed. The difference was significant, $\chi^2$ (2, $N$ = 516) = 7.90, $p < .02$. There was a significant difference on the use of present-tensed verbs between the SFA-therapists.

Finally, a chi-square test of homogeneity was performed to examine the difference on the use of future-tensed verbs between the three SFA-therapists. The difference was significant, $\chi^2$ (2, $N$ = 348) = 53.59, $p < .001$. There was a significant difference on the use of future-tensed verbs between the SFA-therapists.

Table 7 shows the results on the following research question; are there differences within the CBT-group on the use of time?

Table 7

*Chi-square analysis on the use of time within the CBT-group (n = 3).*

| Tense | $\chi^2$ | $p$ |
|---|---|---|
| Past | 8.27 | < .02 |
| Present | 5.09 | .07 < $p$ < .08 |
| Future | 27.11 | < .001 |

*Note.* $df$ = 2 for all chi-squares.

To examine the difference on the use of past-tensed verbs between the three CBT-therapists, a chi-square test of homogeneity was performed. The difference was significant, $\chi^2$ (2, $N$ = 198) = 8.27, $p < .02$. There was a significant difference on the use of past-tensed verbs between the CBT-therapists.

Next, a chi-square test of homogeneity was performed to examine the difference on the use of present-tensed verbs between the three CBT-therapists. The difference was insignificant, $\chi^2$ (2, $N$ = 768) = 5.09, $.07 < p < .08$. There was no significant difference on the use of present-tensed verbs between the CBT-therapists.

Last, a chi-square test of homogeneity was performed to examine the difference on the use of future-tensed verbs between the three CBT-therapists. The difference was significant, $\chi^2$ (2, $N$ = 394) = 27.11, $p < .001$. There was a significant difference on the use of future-tensed verbs between the CBT-therapists.

Table 8 shows the results on the following research question; are there differences between the SFA-group and CBT-group on the use of time?

Table 8

*Chi-square analysis on the use of time between the CBT- and the SFA-group (n = 6).*

| Tense | $\chi^2$ | $p$ |
|---|---|---|
| Past | 5.79 | $.3 < p < .4$ |
| Present | 12.99 | $< .03$ |
| Future | 24.99 | $< .001$ |

*Note*. $df$ = 5 for all chi-squares.

A chi-square test of homogeneity was performed to examine the difference on the use of past-tensed verbs between the CBT and SFA-group. The difference was insignificant, $\chi^2$ (5, $N$ = 458) = 5.79, .3 < $p$ < .4. There was no significant difference on the use of past-tensed verbs between the two groups.

Similarly, a chi-square test of homogeneity was performed to examine the difference on the use of present-tensed verbs between the CBT and SFA-group. The difference was significant, $\chi^2$ (5, $N$ = 1284) = 12.99, $p$ < .03. There was a significant difference on the use of present-tensed verbs between the two groups.

To examine the difference on the use of future-tensed verbs between the CBT and SFA-group a chi-square test of homogeneity was performed. The difference was significant, $\chi^2$ (5, $N$ = 742) = 24.99, $p$ < .001. There was a significant difference on the use of future-tensed verbs between the two groups.

Table 9 shows the results on the following research question; is there a connection between the use of time of the therapist and the use of time of the client?

Table 9

*Chi-square analysis on the use of time between the therapist and client within each session (n = 1).*

| | Groups | | | | | |
|---|---|---|---|---|---|---|
| | CBT | | | SFA | | |
| | Meichenbaum | Persons | Lichtenberg | De Shazer | Berg | Dolan |
| $\chi^2$ | 62.13 | 139.09 | 168.34 | 46.81 | 15.41 | 9.82 |
| $p$ | <.001 | <.001 | <.001 | <.001 | <.001 | <.01 |

*Note*. $df$ = 2 for all chi-squares.

First of all, a chi-square test of independence was performed to examine the relation between the client and Meichenbaum on the use of verb-tenses. The relationship was significant, $\chi^2$ (2, $N$ = 1244) = 62.13, $p < .001$. There was a significant difference on the use of time between the client and Meichenbaum.

Second, to examine the relation between the client and Persons on the use of verb-tenses, a chi-square test of independence was performed. The relationship was significant, $\chi^2$ (2, $N$ = 916) = 139.09, $p < .001$. There was a significant difference on the use of time between the client and Persons.

Next, a chi-square test of independence was performed to examine the relation between the client and Lichtenberg on the use of verb-tenses. The relationship was significant, $\chi^2$ (2, $N$ = 1329) = 168.34, $p < .001$. There was a significant difference on the use of time between the client and Lichtenberg.

Fourth, to examine the relation between the client and De Shazer on the use of verb-tenses, a chi-square test of independence was performed. The relationship was significant, $\chi^2$ (2, $N$ = 1216) = 46.81, $p < .001$. There was a significant difference on the use of time between the client and De Shazer.

Fifth, a chi-square test of independence was performed to examine the relation between the client and Berg on the use of verb-tenses. The relationship was significant, $\chi^2$ (2, $N$ = 923) = 15.41, $p < .001$. There was a significant difference on the use of time between the client and Berg.

Finally, another chi-square test of independence was performed to examine the relation between the client and Dolan on the use of verb-tenses. The relationship was significant, $\chi^2$ (2, $N$ = 906) = 9.82, $p < .01$. There was a significant difference on the use of time between the client and Dolan.

## Conclusion

Considering the inter-rater reliability, this study confirms that the protocol on the use of time (Appendix I) is an appropriate tool for detecting verb-tenses in psychological sessions. This

study achieved a relatively high consensus, since the percentages of agreement are in the range of 71.3% to 100%.

The first research question, which included finding out whether there are differences within the SFA-group on the use of time, can be answered in the following way. All three SFA-therapists differ significantly from each other on all three verb-tenses. The largest difference is found in the use of future-tensed verbs. In conclusion one can say that these SFA-therapists are not homogeneous; the three therapists do not have the same proportion of observations.

The results for the second research question, to find out if there are differences within the CBT-group on the use of time, show more different results. All three CBT-therapists differ significantly from each other on the past- and future-tensed verbs. The largest difference is again found in the use of future-tensed verbs. However, all three CBT-therapists are homogeneous on the use of present-tensed verbs; the three therapists do have the same proportion of observations.

Comparing SFA-group and CBT-group on the use of time show the following results. Both groups show no significant difference on the use of the past-tensed verbs. This means that both approaches are homogeneous on using past-tensed verbs; the six therapists do have the same proportion of observations. Though, there are significant differences found on the use of present- and future-tensed verbs. Again, the largest significance is found in future-tensed verbs.

The fourth research question, which included finding out if there is a connection between the use of time of the therapist and the use of time of the client, can be answered in the following way. For all six sessions significant differences were found on the use of time between each client and each therapist. The smallest significance was found in the Dolan-session. These results show that the verb-tenses from the client and the verb-tenses from the therapist are independent from each other.

As described above, the fifth research question, about finding out whether there is a connection between the use of time and the positive or negative content of the utterance, cannot be answered with the help of statistical tests.

## Discussion

The results of the first research question, which included finding out whether there are differences within the SFA-group on the use of time, are as expected. Because the SFA has clear and undisputed criteria, it was expected that the SFA-therapists would not differ from each other on the use of time. SFA-therapists claim to be future-focused and only talk about the past for the purpose of seeking exceptions.

The results for the second research question, to find out if there are differences within the CBT-group on the use of time, are as expected. CBT can be seen as a denominator which contains diverse forms of therapy. Because of these different forms of CBT, it was assumed that the therapists would differ more from each other. This hypothesis is confirmed on the use of past- and future-tensed verbs.

The third research question, comparing SFA-group and CBT-group on the use of time, show different results. It was expected to find significant differences on the use of past- and future-tensed verbs. The expectation on past-tensed verbs assumed that cognitive behavioural therapists would use more past-tensed verbs. The difference on past-tensed verbs between the two groups is confirmed. Nevertheless, the statistics cannot tell were the difference is found. The expectation assumed that solution focused therapists would use more future-tensed verbs than cognitive behavioural therapists. The difference on future-tensed verbs between the two groups is confirmed. Again, the statistics cannot tell were the difference is found.

The results of the fourth research question, which included finding out if there is a connection between the use of time of the therapist and the use of time of the client, are not as expected. This study assumed that the verb-tense which was used by the therapist, would affect the verb-tense used by the client. For all six sessions significant differences were found on the use of time between each client and each therapist.

## Implications

This study has the following implications for practical use. First, this study has created a protocol to analyse verb-tenses in psychotherapy sessions. The inter-rater reliability of this study suggests that the protocol is a clear guideline for researchers. Second, this form of research, is an addition to the existing discussion whether the solution focused approach is an independent, new kind of therapy or a form of cognitive behavioural therapy. This study shows that the element of 'future-focused', which was an idea of Gooijaarts and Laros (2010), is not typical for solution focused therapists. The third implication is that the results of microanalysis can be used to educate therapists. One can become more aware of his/her personal style of treatment. Besides, it could also make therapists beware of communication techniques they did not know yet. This could lead to an increase of the effectiveness of their therapy.

## Limitations and Recommendations

This study has some limitations. For starters, the chi-square test suffers from some disadvantages. First, the power of the chi-square test is not known. This means that the test does not show the capability to reject the null hypothesis. Therefore, the chi-square test does neither give much information about the strength of the relation, nor about the substantive significance

in the population (Fornell & Larcker, 1981). Chi-square only tells whether there is a difference or not. Second, the chi-square test is sensitive to sample size. The size of the calculated chi-square is directly related to the size of the sample. Consequently, the risk of making a type II error is considerable, even with a large sample size (Fornell & Larcker, 1981). Last, according to Lewis and Burke (1949), no expected (theoretical) frequencies in one or more of the cells should be small.

Besides these statistical restrictions, there are more limitations. Table 1 shows several limitations. First, the presented problems in the sessions do differ a lot from each other. The only resemblance can be found between Meichenbaum and Berg, because these therapists are both working with a client who attempted suicide. However the causes of these attempts differ from each other. The different problems make it more difficult to compare the sessions with each other. Also, Meichenbaum and Berg have the mandatory duty to talk about the suicide attempts because of risk reduction. This leads automatically to the assumption that Meichenbaum and Berg have to talk about the past (and will use past-tensed verbs). Berg has the largest proportion in past-tensed verbs of the SFA-group. Meichenbaum however, does not have the largest proportion in past-tensed verbs of the CBT-group. This could lead to the following assumption: Berg has to talk about the suicide attempt and therefore is using more past-tensed verbs than the other SFA-therapists. In the CBT-group Lichtenberg has the largest proportion in past-tensed verbs instead of Meichenbaum. This might indicate that CBT-therapists differ more from each other in past tensed verbs. Recommendation for further research would be to select sessions which have more resemblance in the presented problems.

Another limitation, which can be found in Table 1, is the fact that not all sessions took place at the same time during the treatment. Five sessions include the first meeting between the

therapist and the client. The Persons-session is the exception; this session is the fourth meeting between the therapist and the client. It is an assumption that in the first meeting, there will be some talking about situations which took place in the past. Since the therapist has to get to know the client and his/her problem. Persons had met her client three times before, and this session has the lowest proportion of past-tensed verbs in the CBT-group. This indicates that this might be a problem in comparing the sessions with each other. However, solution focused therapists assume that they do not have to know the exact problem to help the client. This is assumption is influenced by Watzlawick et al. (1974) who believed that an insight in the cause and origin of the problem is not necessary if one is trying to find a solution. Taking this assumption into account, the SFA-group would not use more past-tensed verbs in the first session than in other sessions. So it would not matter which session was used to analyse the SFA-group. A recommendation would be to select sessions which take place at the same time during the whole treatment.

The next limitation includes the variation of clients. The sessions that were used in this study all work with very different clients. These differences could influence the way the therapists are talking with their clients. For example, Berg is working with a teenage, Afro-American boy and Lichtenberg has an older, Caucasian woman as a client. It is self-evident that Lichtenberg can discuss more past events with his client in comparison to Berg, simply because of the fact that Lichtenberg's client has more experience. Recommendation for further research would include selecting the sessions with more comparable clients. Including variables could be: age, sex and race.

Furthermore, this study had the privilege to work with sessions from founders and/or experts on CBT or SFA. Because these therapists are so familiar with these approaches, they know exactly how to react on their clients from their point of view. In practice, a lot of therapists

might not use these standards as strict as the founders would do. This critical note could bring discount to the external validity of this study. To overcome this limitation, it is recommended to work with more everyday therapists instead of the founders of CBT and SFA.

The fact that microanalysis is very time-consuming leads to the following limitation. This study has analysed six psychotherapeutic sessions, which is a small sample size. This makes it more difficult to generalise the results of this study. It is recommended to analyse more psychotherapeutic sessions which would lead to an increase of the sample size.

The last limitation includes the fact that the fifth research question of this study could not be answered. With this research question, one wanted to investigate if there was a connection between the use of time and the positive or negative content of the utterance. This question could not be answered statistically because the two datasets could not be matched. However, the analysts of this study still presume that there is a connection between verb-tense and the positive and negative content of the verb with SFA and CBT as independent variables. The results of this study show no difference on the use of time between the two groups. However, this study assumes there is a difference in why the two groups use time. A new hypothesis is formed due to this study; SFA- and CBT-therapists do use past-tensed verbs equally, but for a different cause. If SFA-therapists talk about the past, they often explore exceptions: why does the problem not occur? According to the study of Smock et al. (2009), these passages about exceptions have to be labeled as positive, since the therapist and client are talking about problem-free situations. If CBT-therapists talk about the past, they often explore situations in which the problem does occur. CBT-therapists want to discover the underlying thoughts and emotions which lead to the dysfunctional behaviour (the problem). According to the study of Smock et al. (2009), these passages about exceptions have to be labeled as negative, since the therapist and the client are

talking about problematic situations. This new hypothesis breaks with the assumption of Gooijaarts and Laros (2010), which assume that SFA-therapists are more future-focused. According to this study, the new element would be that SFA-therapists use past-tensed verbs for another cause than CBT-therapists. The following example will illustrate this new hypothesis. First, the following scene from the De Shazer-session:

| | |
|---|---|
| Past<br>Present<br>Past, Past | T: Um hmm, um hmm. Well, have there been times in the past, oh, I don't know, six month, a year, um, when you have been able to sleep. |
| Present<br>Present, Present<br>Future<br>Present, Present<br><br><br>Past<br>Past, Past, Past<br><br><br>Present, Future<br>Future, NA, Present | C: Well, he sometimes goes away on the weekends. (T: Um hmm) And if he's gone, um then I know that he's going to come back, (T: Right) sometimes he's gone both days and sometimes he's only gone one day, (T: Um hmm) but um, and then at Christmas, uh, he was gone for about 10 days, (T: Um hmm) so I really felt better then; I was able to get some sleep then. (T: Um hmm, um hmm) But, I never know when he is going to be there and when he's not. (T: Right) you know, (T: Right) I don't ask him. |
| Present<br>Present, Present<br>Past, Past<br>Past | T: Okay. So sometimes on weekends he's gone for a day or two and then you are able to sleep. At Christmas he was gone for 10 days and you were able to sleep better then. Any other times? |

| | |
|---|---|
| Past, Past<br><br><br>Past<br>Past<br>Past<br>(not finished), Past, Past<br>Past | C: When I was able to sleep, or…? (T: Um hmm, um hmm) Um, last Summer, um my two eldest daughters and I and their kids went up to, um, a point up north and rented a cottage on the lake (T: Um hmm) and that was really wonderful, and that was, I was really able to get some sleep. I really felt like myself then, more like my old self. |

De Shazer is using past-tensed verbs and is stimulating the client to use the past-tense verbs, by asking questions about situations in the past in which the problem does not occur. These utterances are indicated as 'positive content' by Smock et al. (2009), because this talk about the past is necessary to find solutions for the problem. The following passage comes from the Meichenbaum-session.

| | |
|---|---|
| Past, Past<br>Past, Past<br>Past, Past<br><br><br>Past, Past, Past, Past<br><br><br>Past, Past, NA | C: Yeah, yeah. When I was in the house, my mom was in the house, and, um, my grandma was leaving him and, uh, he was acting weird and he slept on the floor that night and we had the door locked with all of us in the room. And then that morning, um, I just heard screaming. And I ran out there and he was trying to shoot my mom. And then he, um, you know, then he finally shot my grandma and shot himself, you know, and uh… |
| Past | T: And you witnessed all this? |
| Past | C: Yeah, yeah. It, it's pretty much screwed up the rest of my life at that |

| | |
|---|---|
| NA, Past<br>Past, Past, Present, Present<br>NA, Past, NA<br>Past, Present, Present<br>Past, Present, Past<br>NA | point. You know, ‘cause a year later my brother died, and he was 25, but he was like my protector, you know what I mean? And so, you know, when he was gone, you know, everybody’s heart was broken, you know what I mean? ‘Cause everybody loved him and so after grandma and then him, I mean I was just kind of lost for a while, you know? |
| Past | T: And how did he die? |
| Past, (not finished), Past<br>Past<br>Past, Past<br>Present, Past, Past<br>NA, Past, Past<br>Past, NA<br>Past, Past | C: He got hit by a train. He was, um – they always had a designated driver, and one night they wouldn’t give him a ride home so he walked, and he walked on the railroad tracks, and I don’t know if he fell asleep or, or what happened exactly. But, um, you know, he got hit by the train and, um, they had to pull the plug and he left his little 5-year-old son behind, and you know, he was about to get married and all this other stuff – it was just horrible. |
| Past | T: So you had those three events all occur within 2 years? |
| Past<br>Present<br>Past, Past<br>NA, Past<br>NA, Past | C: Yeah. And then after that my mom just – she was never, never completely mentally stable or anything, but after that, I mean, she just kept getting worse and worse and worse. And it got to a point where, um, you know, she was a problematic drinker but not a heavy drinker, you know, just problematic. And then, um, she got really ill and she, um, |

| | |
|---|---|
| Past, Past<br>Past, Past, Present, Past<br>NA, Past, Past<br>Past, NA<br>Past, Past<br>NA, Past, NA<br>Past, Present, Present<br>NA, Past | she started seeing things, talking to people. I'd have to carry her to the bathtub, carry her out, I mean, she was like 90 pounds, you know, and keep her from drowning in the bathtub. And, and, uh, and then she'd always ask me, you know, tried to get me to commit suicide with her. And, um, and so, you know, obviously by age 12 I was already suicidal, you know, 'cause my mom kind of taught me that's the way to be, so. You know, I did try to commit suicide about seven times. |
| Past | T: You tried to commit suicide seven times? |
| Past<br>Past, Present (repetition 2 x), Past<br>Past<br>Past, Past<br>Past<br>Past, Past, Past<br>Past, NA<br>Past, Past<br>Past, (not finished), Past | C: Yeah. Yeah, um, the first time I slit my wrists, second time I slit my wrists, -- oh no, wait, wait, wait. Um, the first time I did slit my wrists. Second time and third time I took pills, and the rest of the time, um, and then, three other times I went ahead and I did my wrists and my arms again. "Cause I went in the hospital and they said, "Oh you don't do it like that, you do it like that." So I said, "Oh, okay, well thanks a lot," you know. And then, um, the last time was 5 years ago and, um, I took over 200 pills –Tylex, morphine patches, um, Remorin, Cerozone, Thorozine, um, just anything I could grab. And, um, I had I'd known experience that you take too many you get sick so I took some just to get me enough where I could knock myself out and then – but where I know that I would be able to finish taking all the pills. And then my step-dad |

| | |
|---|---|
| Past, Past, Past, Past<br>Past<br>Past, Past, Past<br>Past, Past<br>Past, Past, Past<br>(not finished), (not finished), Past<br>Past, Past | found me. And um, my heart stopped three times and, um, they said if it wasn't for my age, 'cause I was 20 at the time, that I wouldn't have – well I was, I must have been 21 – I wouldn't have survived it. They had to fly me to a different hospital and everything, so. |

The therapist is asking questions about the past and therefore is stimulating the client to talk about the past also. These utterances are nevertheless indicated by Smock et al. (2009) as 'negative content', because the subjects of this passage are negative life events.

It is recommended for further research to investigate whether there is a link between the content and time. To resolve the limitation of this study, it is necessary to make the two datasets (content and time) comparable. This study recommends making the analysis on content more granular. Because each verb in the utterance can indicate a different content. The following example, which is mentioned in the method-section, can illustrate this recommendation.

Lichtenberg #7: "Let's goes through a little bit about that incident. You're talking about your husband, right? (C: um hmm) And you've been married how many years?"

The first sentence is indicated by Smock et al. (2009) as negative, so the verbs in this sentence would have to be indicated as 'negative'. The other two sentences are indicated by Smock et al. (2009) as neutral, so the verbs in these sentences would have to be indicated as 'neutral'. This

solution makes it possible to examine if there is a link between the use of time and type of content.

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Appendix I

**Analyzing Past, Present, and Future in Therapy Sessions**

**J.B. Bavelas & N. Laros, 2011**

Note: It is most efficient to do all of Step 1 for the complete set of data, then proceed and do Step 2 for these data. This is easier than constantly switching from one focus to another.

**Step 1: Highlight the verbs that indicate tense**

In each utterance, highlight each verb that conveys information about the time the speaker is referring to.

*Rule 1: Treat verbs separately unless they act as a unit. That is, keep compound verbs together.*

*Example:*

Therapist: Do you stay the whole day when you get there?

This example has two verbs: "do ... stay" and "get." "Get" is a separate verb. "Do ... stay" is a compound verb; "do" is an auxiliary verb that goes with "stay," so don't separate them. (A verb plus infinitive is also a compound verb; e.g., "I'm supposed to go."

Note: Pay attention to verbs like: want, would, love and like.

- It is possible that they should be analyzed as a compound verb:

  Therapist: "What would you do?"

  This example has two verbs, but is compound. It should be analyzed as 'future'.

- The other possibility is that the verbs should be separated:

Therapist: "Tell me what you want to do with your life?"

This example shows that 'want' and 'to do' should be separated. Because the 'wanting' is already taking place, so this verb should be analyzed as 'present'. The 'doing it' is not yet present, it is a hypothetical future and so, this verb should be analyzed as 'future'.

*Rule 2: Include contractions that are verbs*

Therapist: "... it's a nice name"

The apostrophe and "s" in "it's" stands for the verb, "is."

*Rule 3: Include implicit verbs*

Therapist: So where do you go to school?

Client: Um, West High.

There is no verb in the client's utterance. However, it is implicitly the same verb as the therapist used, that is, "I go to West High." Write the full version (with the missing part} alongside the actual utterance, in brackets, and highlight the implicit verb, for example:

Client: Um, West High. [= I go to West High]

*Rule 4: Utterances not analyzed*

Some utterances are *not analyzed* (NA), that is, not included in the data because they are not informative as to tense. There are several possible reasons:

- The utterance is interrupted or left incomplete

C: “Yeah, and in that kind of situation it is unstoppable. (T: Right) Especially with him; he’s just…. I mean there was a time when I was scared of him.”

The second sentence is clearly not finished and therefore not analyzable.

C: “My best subject so far, right now is, has to be math or algebra 2.”

The client has corrected himself, so the verb ´is´ has no subject and therefore the sentence is not finished, or in other words, not analyzable.

- It does not have a verb tense.

“Hi”

- The utterance is stereotypical and the tense cannot vary.

“I’m Steve.”

- A common example is “you know” when it is inserted stereotypically into another utterance.

C: “No. I’m surprised I made it here today. Well I’m not surprised, but then again I’m actually glad to be here right now because instead of my home being, you know, a couple of blocks away from here (T: right) the school is my home, because I come here to learn (T: Yeah) I come to, you know, succeed, you know, to graduate, because, you know, I want to get that out of the way. Well, yeah, get that done with because some of my family they, you know, most of them didn’t graduate from high school.”

**Step 2: Decide whether each verb is in past, present, or future tense.**

- Apply standard grammar for verb tense.
- Analyze the verb in context, not in isolation
- Be sure to analyze all verbs in the utterance.

Past tense: Verbs that refer to a past event that is over; e.g.,

| |
|---|
| Therapist: So your friends have tried all of [those drugs} |
| Client: Yeah |
| Therapist: Yeah |
| Client: Even passed out. And- it was scary. |

All of these refer to events that have already happened.

Present tense: Verbs that refer to events that (a) are happening in the present or (b) are habitual (an established pattern); e.g.,

| |
|---|
| Therapist: I want to thank you for coming today. |

Both refer to events in the present. The verbs in the following example are asking about her habitual or usual pattern of behaviour, so are all in present tense:

| |
|---|
| Therapist: Yeah, oh, So where do you go to school? |

Or

| |
|---|
| Therapist: How often do you get there? |

Future tense: Verbs that refer to events that have not yet happened; these can also be hypothetical events. For example,

Therapist: I hope this session will be useful in some way.

Note in this example, that the "hope" is in the present but the being "useful" is in the future (later in the session or after the session).

Future perfect tense describes an event in the future that is completed; e.g.,

Therapist: What needs to happen here so that you know it was worth your time coming?

This means "What needs to have happened here so that you will know that it will have been worth your time to have come." It counts, simply, as future tense.

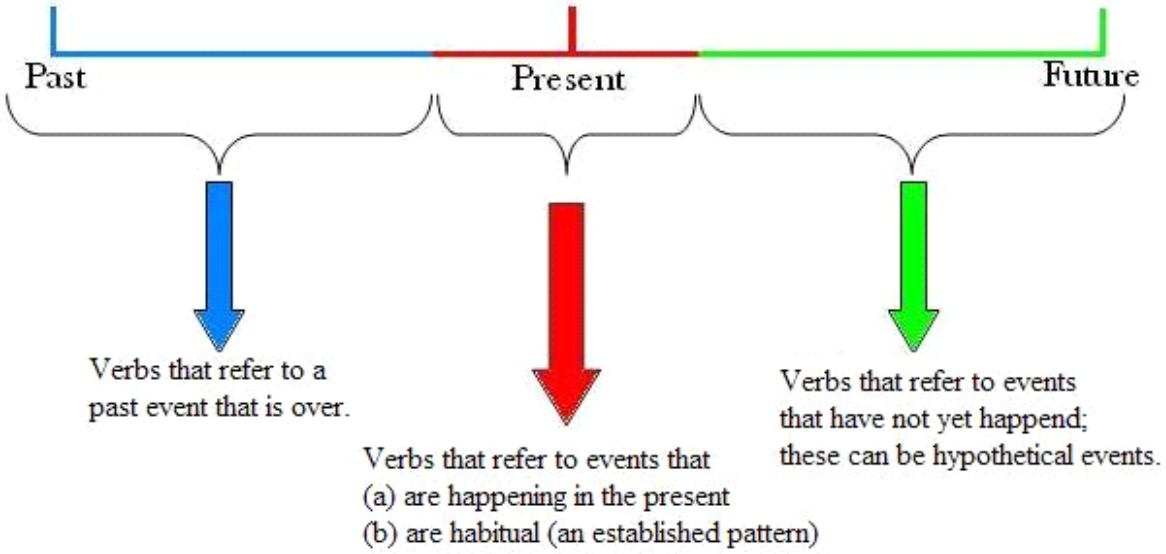
**An important side note:**

It is always important as a viewer to look at the context and not just the literal verb tense. For example, in the context of a story about a past event, the use of another verb tense can make the story more vivid or dramatic, but it is still clear to the viewer that the situation happened in the past.

In other words: time focus > verb tense.

C: And so he kept on bothering me to put on his favorite CD, and I was like, "No, I need to go to sleep. I need to go to school in the morning." (T: Yeah) Well, it didn't work like that. So I got up, knocked on my mom's door, and I told her, I said "Can you please put the CD player up in his room so he can stop bothering me?"

The whole sentence has happened in the past. So every verb has to be analysed as ´past´ even though the verb tense is expressed in another time (e.g. ´I need to go´ is expressed in a future tense).


Past
Present
Future
Verbs that refer to a past event that is over.
Verbs that refer to events that
(a) are happening in the present
(b) are habitual (an established pattern)
Verbs that refer to events that have not yet happend; these can be hypothetical events.

Appendix II

**Positive and Negative Content Analysis Procedures in Therapy Sessions**

**S.A. Smock, A. Froerer, J. Bavelas, 2009**

**Procedure for Analysis**

- Watch the entire tape once to get a sense of the whole interview before analyzing the individual utterances. During this viewing, focus on the topics they talk about, because these form the context of the individual utterances. Also, become familiar with each person's communication style (e.g., speech patterns, phrasings, facial expressions, etc.)

- For *each* analysis, you will watch the whole video again, stopping and replaying as much as necessary. Go through the tape in sequence, focusing on the therapist's utterances. Don't skip over the client's utterances, though, because they are often essential for context. Use the transcript to record your decisions but not to make them; *always watch and listen to the video*.

- Whenever you can't hear the entire utterance or can't understand a part of it, it is not analyzable (this includes talk that is hard to interpret); see below for examples. If any part of the utterance is hard to hear or interpret, circle "NA" in the margin and skip that utterance for all subsequent analyses.

- *Positive analysis*: Watch the whole video again, looking for parts of therapist utterances that are *positive*. Using the criteria below, underline the parts of the therapist's

utterances that are positive, put a "+" sign above them, and circle the "+" in the margin. No underlining and no circle means there was nothing positive in the utterance."

• *Negative analysis*: Go through the whole video again. Using the criteria below, underline the parts of the therapist's utterances that are *negative*, put a "-" sign above them, and circle the "-" in the margin. Note that there can be negative parts of an utterance that also had positive parts, but they can't be the same parts.

• *Last check*: Finally, go back to any utterances that don't have "+" or "–" or "NA" in the margin, and double-check that there are really no negative or positive parts and that it really is analyzable. If so, circle "N" for "neither positive or negative." See below for examples.

• In doing all of these analyses, remember not to be too inferential. Content that is positive or negative should be clearly positive or negative based on what the therapist actually said—*not* based on what we think the therapist's intention or purpose was.

• Also, it is impossible for you to say with some certainty whether the utterance is positive content or negative content, then mark it as non-analyzable. Utterances should be clearly positive content or negative content to be marked as such. In other words, utterances that appear to have a value (positive or negative), but it is unclear

due to tone of voice or another factor if they are positive or negative content, mark as non-analyzable.

**Example 1: Non-analyzable**

**Th**: What do you do with yourself all day?

**Cl**: Not much.

**Th**: *I imagine.*

In this example, the utterance "I imagine" is non-analyzable due to the inflection in the therapist's voice. It is hard to tell if the therapist is being positive or negative in this utterance so it is marked as non-analyzable.