**Abstract**

**Background**: Intake assessments vary in their focus on strengths and solutions compared to problems. They provide therapists with first impressions of their clients. Research shows that first impressions may have strong and lasting effects.

**Aims**: To compare how solution- versus problem-focused case descriptions influence therapists’ emotions and expectations for successfully working with a client.

**Methods**: Vignettes describing clients were manipulated to focus either on solutions and strengths or on problems. In a within-subject experimental design, 33 (Sample 1) and 29 (Sample 2) trainee therapists each read four case descriptions (two solution-focused and two problem-focused vignettes; order fully counterbalanced). After each vignette, participants rated their affect and expectations for successfully working with the client.

**Results**: In both samples, solution-focused vignettes were associated with significantly higher levels of positive affect and positive expectations for treatment, and with significantly lower levels of negative affect, compared to problem-focused vignettes. Effect size differences between conditions were generally large (Cohen’s d between .63 and 1.22).

**Conclusions**: Focusing on clients’ goals, their strengths, and actively highlighting better moments and areas of problem-free functioning may increase therapists’ positive emotions and their hope for successfully working with a client. A next step is to examine the degree to which these positive initial effects are, in turn, predictive of better clinical outcomes in therapy. Future research could additionally examine whether supporting therapists to frame clients’ initial assessments in solution-focused ways may be one way to contribute to workforce well-being.

**Key words**: solution-focus; problem-focus; therapist emotions; hope for treatment; intake assessment; intake report

When clients apply for treatment at a mental health care institution, they usually go through an intake assessment first. The goal of the intake assessment is to obtain a clear focus on present and past concerns, and typically involves completion of multiple interviews and questionnaires (American Psychological Association, 2021). During the intake assessment, the therapist asks the client to provide detailed information on current and previous problems, and on factors that potentially maintain or contribute to these problems. Many psychological therapies are based on the assumption that detailed information about a problem is necessary in order to treat a problem (Bannink & Geschwind, 2021), with intake assessments therefore usually being relatively focused on describing problem-content.

Several approaches advocate taking a balanced perspective and using the intake assessment also to identify client’s strengths and resources, in addition to a detailed description of problems (Dunn, 2019; Kuyken et al., 2009; Meyer & Melchert, 2011; Padesky & Mooney, 2012). Solution-focused approaches such as solution-focussed brief therapy (de Shazer et al., 2021) or positive cognitive behavioural therapy (Bannink, 2014) take the focus on strengths and resources one step further by questioning the need for extensive knowledge about clients’ problems (de Shazer et al., 2021). Instead, solution-focused approaches emphasize the need to obtain a detailed image of clients’ preferred future, and focus on identifying problem-free areas and strengths that clients can use as stepping-stones on the path towards that future (Bannink & Geschwind, 2021).

Because the intake assessment usually provides therapists with a first impression of a client, the content of the intake assessment (i.e., primarily problem- or primarily solution-focused) is likely to substantially shape clients’ and therapists’ formulation of the work that needs to be done over therapy. Cognitive processes such as the Anchoring Effect suggest that information obtained early on has a long-term impact on decision-making(Furnham & Boo, 2011; Tversky & Kahneman, 1974). Illustrating the effects of the Anchoring Effect, recent research shows that first impressions are slow to update and have a disproportionate influence on later decision-making such as whom to promote even six years later, compared to later indicators of performance (Black & Vance, 2021). The intake assessment therefore is likely to influence therapists emotionally, with a possible downstream impact of therapists’ emotions on their decision-making, therapeutic optimism, and potentially even therapeutic effectiveness (Coppock et al., 2010).

Theories such as the Broaden and Build Theory predict that positive emotions help individuals to come up with a wider range of ‘thought-action repertoires’ (i.e., a wider array of ideas for potentially helpful approaches, interventions or reactions to treatment obstacles; Fredrickson, 2001). Therefore, if therapists are able to take a strengths-based view and cultivate positive affect during the intake assessment and in the early sessions of treatment, this may help both the client and therapist to increase their sense of possible steps that can be taken to help the client.

However, empirical research examining the influence of therapists’ emotions and expectancies on how therapy progresses is scarce. A grounded theory analysis found that therapists viewed their in-session positive emotions as increasing their resourcefulness and the daring of their actions (Vandenberghe & Silvestre, 2014). Additionally, a naturalistic treatment study found that higher levels of therapist hope positively predicted clients’ treatment outcomes (Coppock et al., 2010). Concepts related to therapists’ emotionality, such as their expression of positive regard towards their clients, have similarly been found to predict variance in treatment outcome (Farber & Doolin, 2011). While these qualitative or observational studies provide tentative support for the notion that therapists’ positive emotions may shape how therapy progresses, they do not provide evidence for causal effects. Moreover, these studies are agnostic as to the degree to which therapists had adopted a problem-focused versus solution-focused outlook in the first place.

The main aim of the current study is to provide a first step towards examining the impact that information collected during intake assessments may have on therapists’ emotions and their expectations for successfully working with a client. In line with previous publications studying the impact of client information on health professionals’ attitudes (Chartonas et al., 2017; Lam et al., 2016; Noblett et al., 2015), the current study asked participants (trainee therapists) to read vignettes with short case descriptions that imitated information from intake reports. To facilitate causal inferences, we used an experimental setup that isolated and manipulated the content of case descriptions (problem- vs. solution-focused). The current study is the first to experimentally test the idea that the content of intake descriptions influences therapists’ emotions and their outlook on therapy success. Therefore, this study focused on the extremes by comparing pure solution-focused with pure problem-focused case descriptions in order to provide a first proof of principle. To enable reliable within-subject comparisons while avoiding fatigue and achieving similar vignette lengths, we did not include case descriptions that combined both types of information.

Compared to problem-focused vignettes, we expected solution-focused vignettes to be associated with (i) higher positive affect, (ii) lower negative affect, and (iii) higher therapist positive expectations for working with the client. For direct replication, the study was executed in two samples of students undergoing therapy training, one in the Netherlands (Sample 1), and one in the United Kingdom (Sample 2).

**Methods**

**Study design and statistical analysis**

The current study employed a within-subject experimental design with condition (solution-focus vs. problem-focus) as independent variable. Participants rated four vignettes, of which two were solution-focused and two were problem-focused. The order of the vignettes was fully counterbalanced (i.e., full permutation of all orders). Outcome variables (positive affect, negative affect, and positive expectations related to working with a client) were averaged per participant per condition. Then, the effect of condition was examined through paired t-tests contrasting the effects of solution- versus problem-focused vignettes (Moerbeek et al., 2003). Analyses were run separately for each sample. Power analysis indicated a required sample size of 30 participants to identify medium effect sizes with a power of 0.9 and an alpha error probability of 0.05, assuming a moderate correlation in-between measurements (G\*Power 3.1.6; Faul et al., 2009).

**Procedure**

Ethical committees of Maastricht University and University of Exeter both approved the study (reference numbers ERCPN\_177\_04\_03\_2017 and eCLESPsy000217, respectively). The study was preregistered on aspredicted.org (see <http://aspredicted.org/blind.php?x=nt6zv6>). Participants were psychology or mental health students who had completed at least one clinical skills course (Sample 1; the Netherlands), or fourth-year undergraduates in training to become psychological wellbeing practitioners (all currently enrolled in clinical placements in Improving Access to Psychological Therapy (IAPT) settings; Sample 2, UK). At the time of the study, students in sample 2 thus were slightly more experienced than participants from sample one.

Potential participants were invited to take part in the online study through an e-mail containing an information letter and the link to the online study programmed in Qualtrics. In order to avoid response-bias, we employed a cover story. In the cover story, we informed participants that the goal of the study was to assess trait mindfulness and its impact on participants’ ratings of client vignettes. Participants were not informed that there were two types of vignettes (i.e., solution or problem focused).

The study took place online. After providing informed consent in Qualtrics, participants first answered a few demographic questions (such as age, clinical experience, nationality) and completed the mindfulness questionnaire. Then, four vignettes were presented one by one. Participants were asked to read each vignette attentively, as they were not allowed to go back and reread the descriptions. After each vignette, participants rated their current affective state and their expectations for working with that client, see section ‘Measures’. Participants were also asked to summarize their first impression of the client in a couple of sentences. Lastly, participants answered a couple of manipulation check questions about their ability to imagine themselves as the therapist of the clients presented in the vignette, and the extent to which they put effort into this study. After completing the study, participants received a debriefing form describing the actual research question. To compensate for their time, participants either received a gift voucher worth 5EUR or 5GBP, depending on their location (the Netherlands or UK).

**Case descriptions**

A series of short vignettes (range 519 to 660 words) described four imaginary clients with mood-disorders (two men, two women). The word count did not differ between conditions (*t*(6)=8.50, *p*=.423; *M*=605.25 and *SD*=49.90 for the solution-focused vignettes; *M*=575,25 and *SD*=48.84 for the problem-focused vignettes). A solution-focused and a problem-focused version were created for each client, resulting in eight vignettes.

Participants rated four vignettes, one for each client; two of the four vignettes were solution-focused, and the other two were problem-focused. The order of SF and PF vignettes was fully counterbalanced, taking into account both condition and client, resulting in a list of 32 unique variations in which each combination of conditions and clients occurred equally often. For instance, across 32 participants, the solution-focused and the problem-focused description of Julia each would appear 16 times. Below, we shortly describe the buildup of vignettes per condition.

The Appendix provides examples of solution- and problem-focused vignettes. Note that the tone and content of the case descriptions differs dramatically as a result of the different types of question that would be asked during a solution-focused versus problem-focused intake, analogue to seeing different things when shining a spotlight onto different elements in a dark room. Therefore, we asked a clinical psychologist with decades of experience in solution-focused and problem-focused ways of working to look at both versions of the same client and rate the likelihood that both vignette versions stemmed from the same case. This likelihood was rated as high (8.5 out of 10 for each client on a 10-mm Visual Analogue Scale (VAS) ranging from 0 [not at all probable] to 10 [very probable]).

***Solution-focused descriptions***

The solution-focused vignettes provided information such as would be obtained by asking solution-focused scaling questions (Bannink, 2007; de Shazer et al., 2021). Solution-focused scaling questions use a scale ranging from 10 (ideal) to 0 (the opposite). First, the therapist asks for detailed information about the ideal future and what clients want their lives to look like after therapy (i.e., the goal). Second, after talking in detail about earlier successes and better moments, clients are asked to rate their current situation on the scale. The therapist here pays particular attention to why clients rate their current situations as a ‘3’, for example, and not lower, thus highlighting what is still going relatively well. Finally, the client is asked to visualize one step higher on the scale and describe what their live would look like then (i.e., first signs of improvement).

The solution-focused vignettes consisted of the sections ‘Short Problem Description’ (short background information on the problem), ‘Goal Formulation’ (describing the ideal future and a detailed image of how the clients envisage their lives after successful therapy), ‘Better Moments/Exceptions to problems’ (describing moments when clients’ mood is better), and ‘Scaling of Improvement’ (on how clients rate their situation now and what is still working for them, as well as first signs of improvement).

To illustrate, the solution-focused version of Julia’s intake report first informs participants of her symptoms of depression triggered by her miscarriage plus subsequent break-up with her fiancé. Second, the section ‘Goal Formulation’ describes what both the ideal (long-term) situation and the (mid-term) result of therapy look like for Julia: On the long term, she wants to feel energetic and confident again. She would then set up special music classes in her job as teaching assistant, write her own songs, and give back to her friend Helen, who has helped her a lot. By the end of therapy, Julia would want to work 6 hours per day and have enough energy left to engage in pleasant activities, experiment with music, and baby-sit Helen’s kids twice a month. Third, the section ‘Better moments/exceptions to problems’ describes moments when Julia has felt a little more energetic and confident in the last few weeks, e.g., when, a couple of weeks ago, her colleague complimented her on one of the songs she wrote for her class last year, or when she takes care of her rabbit in the evenings. Fourth, the section ‘Scaling of Improvement’ describes how Julia currently positions her situation at a 3 on the scale of 10 (ideal) to 0 (the opposite), and how Helen’s support and Julia’s enthusiasm for her job have kept her going despite her problems. This section also provides information on what Julia sees as next signs of improvement: returning to work for an additional hour per day, and asking whether she can teach the youngest class in this extra hour.

***Problem-focused descriptions***

The problem-focused vignettes provided information such as would be obtained by asking detailed questions about current problems, their origin, and maintaining factors.

The problem-focused vignettes consisted of the sections ‘Anamnesis of current complaints’ (providing an overview of current complaints and their development, including potential triggers and recent life events, maintaining factors and clients’ reason for seeking help), ‘Relevant Developmental Information’ (describing family of origin and formative experiences), ‘Medical History’ (mentioning relevant medical history), and ‘Psychiatric History’ (mentioning earlier diagnoses, if any).

To illustrate, the problem-focused version of Julia’s intake report first provides details about her current depressive complaints, symptoms, and triggers, i.e., how the miscarriage and subsequent break-up triggered lethargy and lack of energy, how she now sleeps a lot and has gained 10 kg over the past eight months, how she has one good friend but reports pushing her away and feeling unworthy of her friendship, and that she would like to stop feeling so tired and numb and feel able to participate in life again. Second, the section ‘Relevant Developmental Data’ describes how Julia grew up as the only child of two older parents, with whom she never felt extremely close but also not estranged, that she used to have friends and musical hobbies at school, and sees herself as an introverted person who is helpful and reliable and interested in culture. Also, this section describes how Julia met her ex-fiancé (with whom she was together for almost 10 years) at high-school, how he proposed to her when she got pregnant but broke up with her a while after the miscarriage. The sections ‘Medical History’ and ‘Psychiatric History’ describe that Julia had only been hospitalized once for a broken arm in childhood but has not had any other medical issues, and that she is unaware of any family psychiatric history and has not been to a therapist before. See the Appendix for the full problem- and solution-focused versions of Julia’s intake report.

**Measures**

***Outcome measures assessed after each vignette***

After each vignette, participants rated their current affective state and their expectations for working with the client on several 100-mm VAS with anchors 0 (not at all) to 100 (very much). The timeframe for the affective state was “How do you feel right now, after reading this case description?“. Both samples were combined for an exploratory factor analysis using the Principal Axis Factoring technique and a Varimax rotation (combined N=62). This factor analysis suggested two factors for the items assessing current affective state (i.e., positive affect and negative affect), and one factor for the items assessing expectations for working with a client.

**Positive affect.** Positive affect was calculated as the average of the variables cheerful, content, hopeful, and enthusiastic. In line with guidelines for exploratory factor analysis (Centre for Academic Success; Birmingham City University, 2017), the variable ‘calm’ was removed because it loaded too strongly on both factors (calm’s loading on Negative Affect was >75% of the loading on Positive Affect). Cronbach’s alpha was .880.

**Negative affect.** Negative affect was calculated as the average of the variables anxious, frustrated, and sad. Cronbach’s alpha was .667.

**Positive expectations.** Positive expectations for working with a client were calculated as the average of the following variables: ‘How much would you like being this client’s therapist?’, ‘How much would you like to start working with this client?’, ‘How confident are you that you can help this client get his/her life back on track?’, and ‘To what extent do you believe that this client will be able to accomplish his/her goals?’. Cronbach’s alpha was .912.

***Other measures***

**Manipulation check.** At the end of the study, participants were asked to rate the following six items. First, in order to characterize their subjective experience of participating in the study, participants indicated to what extent they had experienced participation as (1) stressful, (2) fun, and (3) boring, using 100-mm VAS with anchors 0 (not at all) to 100 (very much). Second, in order to measure the believability of case descriptions as well as participants’ motivation, participants indicated to what extent they agreed with the statements (4) ‘I thought that the case descriptions were believable’, (5) ‘I was motivated to complete this study to the best of their abilities’, and (6) ‘I was able to vividly imagine myself as a beginning therapist of these clients’, using 100-mm VAS with anchors 0 (I disagree) to 100 (I agree).

**Mindfulness.** In order to support our cover story that we investigated therapist trait mindfulness, participants completed the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003). The MAAS consists of 15 items answered on a 7-point Likert scale with labels ranging from 1 (almost always) to 6 (almost never). Items are averaged to form a total score between 1 and 6. Given that the items of the MAAS assess frequency of inattentive behaviors, higher scores indicate higher mindfulness.

**Results**

**Participants**

In Sample 1, 36 participants started with the study but two dropped out before completing the baseline information, and another one dropped out before rating at least one case of each condition, resulting in 33 participants with a relevant contrast between conditions. In Sample 2, 36 participants started with the study but five dropped out before completing the baseline information, and another two dropped out before rating at least one case of each condition, resulting in 29 participants with a relevant contrast. In Sample 2, one participant had stopped after rating three cases. This participant was retained in the analysis, as the three cases did allow for a comparison between both conditions. All other participants had completed all four cases. Table 1 shows participant characteristics and baseline measures. In sample 1, 33.3% had some form of experience working with clients with mental health problems in practice (e.g., through internships, voluntary work, or paid work, while 66.7% did not have practical experience yet. In sample 2, all participants were currently in their IAPT service placements and had real-life experience working with clients.

**Manipulation checks**

As Table 2 shows, the majority of participants in both studies perceived participation as moderately fun, and reported feelings of stress and boredom were low. Participants reported that they found the case descriptions highly believable and were very motivated to participate. On average, sample 1 rated their ability to imagine themselves as therapists with 64.03 out of 100, while participants in sample 2 rated their ability with 80.29, in line with their higher levels of practical experience with clients.

**Table 1**

***Participant characteristics***

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Sample 1 (*N*=33) | Sample 2 (N=29) |
| Female gender, n (%) | | 29 (87.9 %) | 29 (100 %) |
| Age, *M* (*SD*) | | 23.82 (3.96) | 21.45 (1.35) |
| Experience working with clientsa, *n* (%) | |  |  |
|  | Internship / placement | 9 (27.3 %) | 29 (100 %) |
|  | Voluntary work | 5 (15.2 %) | 17 (58.6 %) |
|  | Paid work | 4 (12.1 %) | 6 (20.7 %) |
|  | None | 22 (66.7%) | 0 (0 %) |
| Mindfulness (MAAS), *M* (*SD*) | | 3.78 (.57) | 3.86 (.75) |
| MAAS = Mindful Attention Awareness Scale.  a Percentages do not add up because multiple responses were allowed, e.g. internship and paid work. | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 2**  ***Manipulation checks*** | | | | |  | | |  |
|  | Sample 1 (*N*=33) a | | Sample 2 (*N*=28) b | | | |
| Variable | *M* | *SD* | | *M* | | *SD* |
| Stressful | 15.19 | 15.80 | | 14.00 | | 17.21 |
| Fun | 46.09 | 20.94 | | 38.46 | | 18.99 |
| Boring | 28.58 | 25.21 | | 21.93 | | 16.91 |
| Believable | 82.58 | 11.00 | | 82.75 | | 17.70 |
| Motivated | 80.24 | 14.31 | | 82.30 | | 18.05 |
| Able to vividly imagine scenarios | 64.03 | 22.37 | | 80.29 | | 20.98 |
| *Note*. All items were rated on a scale of 0-100. | | | | | | |

a Because the manipulation check items accidentally had not been set as forced entry, one participants had skipped the question ‘stressful’.

b N=28 because one participant had stopped before the manipulation check. Additionally, because the manipulation check items accidentally had not been set as forced entry, some participants had skipped a question. N ranged between 25 for stressful and 27 and 28 for the other questions.

**Main Outcomes**

Table 3 shows the results of the paired samples t-test for each sample. In both samples, after rating solution-focused vignettes, participants experienced significantly more positive affect and less negative affect, compared to problem-focused vignettes. In addition, expectations for successfully working with a client were significantly more positive. Effect sizes were large (Cohen’s d > .8) for all outcomes, except for the effect size of negative affect in Sample 1, which was medium. Figure 1 illustrates the magnitude of the difference between conditions per outcome variable and sample.

**Table 3**

**Effect of solution- vs. problem-focused vignettes on therapist affect and their expectations for successfully working with a client**

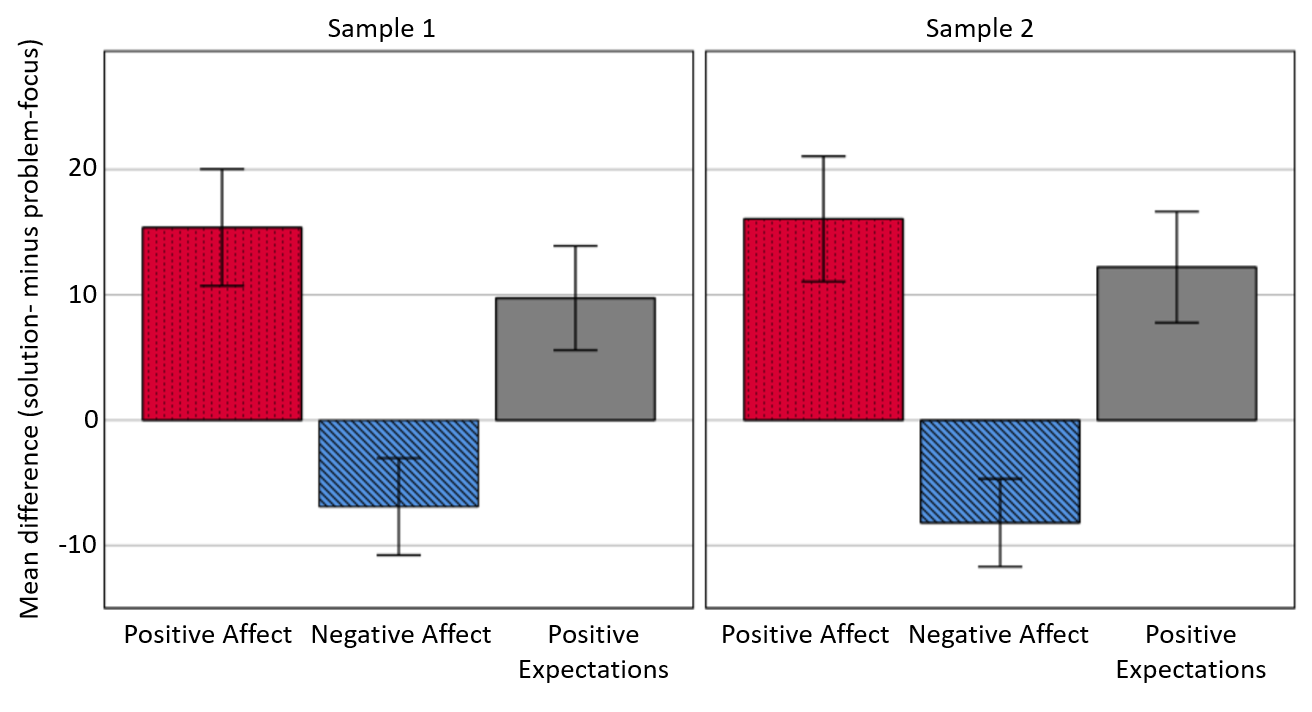
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | | Sample 1  (N = 33) | | | |  | | Sample 2  (N = 29) | | | | |
|  | Solution-focus  Mean (SD) | | Problem-focus Mean (SD) | | *t* | *p* | Cohen’s da | | Solution-focus  Mean (SD) | | Problem-focus  Mean (SD) | *t* | *p* | Cohen’s da |
| Positive  Affect | 53.39 (19.20) | | 38.01 (21.93) | | 6.71 | <.001 | 1.17 | | 56.17 (18.70) | | 40.11 (23.40) | 6.58 | <.001 | 1.22 |
| Negative  Affect | 12.23 (9.98) | | 19.13 (14.31) | | -3.03 | .001 | -.63 | | 13.51 (11.57) | | 21.70 (13.43) | -4.78 | <.001 | -.89 |
| Positive  expec-  tations | 74.31 (12.95) | | 64.56 (17.28) | | 4.77 | <.001 | .83 | | 77.31 (15.80) | | 65.10 (18.69) | 6.64 | <.001 | 1.05 |

*Note*. Results of paired samples t-tests for each sample. Outcome variables were rated on a scale of 0-100. Positive values for Cohen’s *d* suggest greater scores in solution- relative to problem-focused vignettes, whereas negative values suggest lower scores in solution- relative to problem-focused vignettes.

a Cohen’s *d* for a paired-samples t-test is calculated by dividing the mean difference by the standard deviation of the difference.

**Figure 1**

*Mean differences between solution-focused and problem-focused vignettes*



*Note*. Outcome variables were measured on a scale of 0 to 100. Error bars represent 95% Confidence Intervals. Positive values suggest higher scores for solution- relative to problem-focused vignettes; negative values suggest lower scores for solution- relative to problem-focused vignettes.

**Discussion**

The aim of the current vignette study was to compare the effects of solution-focused versus problem-focused case descriptions on therapists’ emotions and therapeutic optimism in a within-person comparison. Outcome variables were positive affect, negative affect, and therapists’ expectations for successfully working with a client. To test the hypotheses that reading solution-focused case descriptions would induce higher positive affect, lower negative affect, and higher positive expectations of treatment success compared to problem-focused case descriptions, participants were asked to imagine themselves as beginning therapists taking on potential clients. Participants then rated four vignettes each (two solution-focused vignettes, and two problem-focused vignettes) in counterbalance order.

**Findings**

The study was replicated in two different samples. In sample 1, participants were psychology or mental health care students who had minimally completed a clinical skills training. In sample 2, participants were students of applied psychology who were in the midst of their clinical placements as IAPT Psychological Well-being Practitioner. In both samples, the results were fully in line with our hypotheses. After reading solution-focused vignettes, participants reported significantly higher positive affect and significantly lower negative affect, in addition to having significantly higher positive expectations for successfully working with a client, compared to after reading problem-focused vignettes. Effect sizes were large (Cohen’s d > .8) for all outcomes, except for the effect size of negative affect in Sample 1, which was medium (Cohen’s d = .63).

**Comparison with other studies**

To the best of our knowledge, this study is the first study to experimentally manipulate the content of case descriptions in terms of their focus on strengths and solutions versus problems, thereby enabling an experimentally controlled assessment of the isolated impact of solution- versus problem-focus on *therapist* emotions and hope for treatment. Even though no direct comparisons are available, the finding that solution-focused case descriptions elicited more positive affect, less negative affect, and higher expectancies for successful treatment, compared to problem-focused case descriptions resonates with a number of studies investigating the impact of solution- versus problem-focused questions on *clients’* emotions (see Grant & O’Connor, 2018 for an overview). Most of these studies focused on short-term change (pre-post session outcomes), used questionnaires rather than interviews, and used convenience samples (i.e., psychology students rather than clients with mental health problems). These studies generally found that solution-focused questions were associated with more positive affect, lower negative affect, and higher ratings of goal attainment, compared to problem-focused questions.

In sum, the findings of the current study complement the available literature. Where our experimental study links solution- and strengths-focused case descriptions to higher positive emotions and expectancies for treatment in therapists, other studies have reported beneficial effects of solution-focused questions on positive emotions in clients.

**Implications**

The results of this study suggest that information about clients gathered during the intake assessment and subsequently presented in an intake report may have a significant impact on therapists’ emotions and their expectations for treatment success, including how much they would like to work with a client. Gathering detailed information about clients’ preferred future, their strengths, and exceptions to problems (moments during which the problem is absent or less pronounced, or moments during which they can cope better) may help therapists to feel more positive about chances of successfully collaborating with clients. In addition, therapists may want to systematically add a section on client strengths to their intake formulation, and pay attention to formulating detailed, approach-related goals, as this may lead to better therapist attitudes towards the course of therapy. Training therapists to be mindful of their initial responses after assessments, and focusing supervision on these initial responses may be helpful to prevent negative downstream effects of first (problem-saturated) impressions.

Taking a strengths-based view and cultivating positive affect may also help to preserve mental well-being and to prevent burnout in therapists (Fredrickson & Joiner, 2002; Kiken & Fredrickson, 2017). There is increasing recognition of the challenges of preserving workforce well-being in often pressurised health services environments, and that a failure to do so can lead to poorer clinical outcomes and higher rates of workforce absenteeism, presenteeism, and turnover (West et al., 2022). The present results provide preliminary evidence that supporting therapists to frame clients’ initial assessments in solution-focused ways could be one way to cultivate positive affect and preserve workforce well-being.

Given that a previous study found that therapists’ hope for treatment positively predicted treatment outcomes (Coppock et al., 2010), clients too may benefit from therapists feeling more positive. In a grounded-theory study on the function of therapists’ in-session positive emotions, therapists themselves identified their positive emotions as contributing to increased in-session awareness, daring and resourcefulness on their side (Vandenberghe & Silvestre, 2014). In addition, being asked about strengths and other positive information during the intake procedure may increase clients’ own hope for treatment. A recent study found that clients’ *hope for counselling* (i.e., hope that is domain-specific to treatment rather than general or trait hope) predicted decreases in distress (Bartholomew et al., 2021). Moreover, according to theories about the function of positive emotions, people who feel more hopeful and optimistic are likely to persist longer and find more ways to deal with treatment obstacles (Fredrickson, 2004; Grant & O’Connor, 2018; Kiken & Fredrickson, 2017; Snyder et al., 2000; Snyder, 2002; Van Cappellen et al., 2018). This, in turn, should apply to both client and therapist, thereby benefitting treatment outcomes.

**Strengths, Limitations and Suggestions for future research**

Strengths include the study’s within-subject design, which eliminated random noise between conditions. Another strength is the high degree of control achieved through carefully matching the content of descriptions and counterbalancing the order of vignettes. In addition, we directly replicated the results in two different samples.

Limitations include the following: First, the current study is an analogue study, using students in clinical training programmes as participants, instead of fully qualified therapists. This choice was largely due to convenience, with fully trained therapists being difficult to recruit given current time-budgeting pressures in the field of mental health care. The fact that results in sample 2 (where students had higher levels of practical experience) fully replicated the results found in sample 1 suggests that practical experience may not be a very relevant factor. Nevertheless, it would be interesting to investigate whether the beneficial impact of positive information on therapists’ emotions changes with long-term experience in the work field. Second, no ‘blended’ vignettes were included (i.e., vignettes with an equal balance on problem- and solution-focused information). The reason for not including ‘blended’ vignettes was that we wanted to ensure similar word counts within the context of this within-subject design with repeated measurements, and vignettes would have needed to be significantly longer to meaningfully include both types of information. Third, the results of the current vignette provide only a short-term snap-shot of the impact of first impressions on student therapists’ emotional experience that cannot be directly linked to long-term mental health outcomes or to treatment success. Nevertheless, even though we could not identify research on the impact of first impressions in clinical practice, research in other fields indicates that first impressions can have lasting impact and are slow to update, with initial assessments disproportionally influencing managers’ promotion-related decision-making for up to six years (Black & Vance, 2021). Fourth, we did not explicitly check if participants saw through the façade and realized the true purpose of the study.

Taking into account the limitations mentioned above, suggestions for future research include the following: First, findings should be replicated in fully trained therapists. Research could also investigate to what extent different levels of therapist experience impact therapists’ emotional responses. Second, to make inclusion of positive information more relevant to institutions providing problem-focused treatments, studies should compare solution- and problem-focused intake approaches to ‘blended’ intake formats, in which a problem-focus is amplified with information on strengths and better moments. Third, future studies should systematically compare the effects of solution- and problem-focused intake procedures in real-life clinical settings, investigating the effects of these intake procedures on clients’ and therapists’ levels of hope, optimism and well-being as well as on long-term clinical outcomes. Fourth, it would be interesting to investigate the impact of different intake assessment formats on clients’ emotional responses.

**Conclusions**

The current study suggests that eliciting and providing information about clients that highlights their strengths and includes identification of problem-free areas may be beneficial for increasing therapists’ positive emotions and hope for successful collaboration with clients. Examples of information that may be useful to include during intake assessments are clients’ strengths, exceptions to problems, and positively formulated goals that provide a detailed image of the life that clients envision after therapy.

**Ethics statement**

The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. Ethical committees of Maastricht University and University of Exeter both approved the study (reference numbers ERCPN\_177\_04\_03\_2017 and eCLESPsy000217, respectively).

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Appendix

1. **Examples of Solution-focused vignettes**

**Dean McCoy, male, 28 years old, train conductor.**

**1 Short Problem Description**

Dean has sought help through his medical officer because he has been feeling irritable, worn out, anxious, has trouble concentrating, as well as fleeting suicidal thoughts (no concrete plans, though). These problems started 2 months ago, when he found out that his girlfriend cheated on him and he subsequently left her. He went on sick leave 3,5 weeks ago, because he was unable to focus on his work and received a warning from his boss after nearly causing an accident.

**2 Goal Formulation**

In the best case scenario, Dean will be head conductor (he always believed that he was hard working enough to achieve this), be in a loving relationship with someone, and have a family that brings him joy and that he can take care of. He will feel independent and secure enough to travel around the world – something he has always wanted to do. He will then feel positive and self-confident. He rates this scenario as the ideal situation (10 on the scale of 10 [ideal] to 0 [the opposite]).

As a result of therapy, Dean wishes to improve his current situation to an 8 out of 10. At an 8, he will be able to concentrate, he will feel energized and confident in what the future holds, and he will be the outgoing person he used to be before his problems started. He will be confident about meeting new people and start meeting girls, maybe through an online dating platform. He will also be back in his job as train conductor. With regard to his family, Dean will skype with his twin brother in Australia more often, and visit his parents approximately once a week. Furthermore, at an 8, Dean will meet up with friends twice a week and go to the mountain biking club meetings on Sundays.

**3 Better moments / Exceptions to problems**

Dean used to enjoy going to the mountain biking club meetings. Although he has not been for a couple of months now, the memory of attending it every week is a happy thought. He likes his work as a train conductor; this is exactly the job he dreamt of when he was a little boy. He has a good relationship with some of the colleagues there. When he speaks with his twin brother Alex, they can laugh together and share jokes, which temporarily lifts his mood. With one of his friends, who is divorced, he can talk about his current difficulties and then feels understood. When his mother drives the 30 km to his home just to bring him home cooked lunch, he feels cared for.

**4 Scaling of Improvement**

Currently, a typical day for Dean mainly consists of watching TV. Occasionally, he has a check-up with his medical officer. Sometimes, he manages to visit his parents. For Dean, a typical day is at a 3 (and not lower) because he realizes that he does have things in his life that he is grateful of: his caring parents, his brother, his job that he believes he will be able to get back to, and the friends he has had since high school.

First signs of him improving (a 4 out of 10), he believes, are feeling slightly more energetic, asking one of his mates over for a Netflix evening, and attending the mountain bike club meetings.

**Julia Keller, female, 29 years, assistant teacher.**  
  
**1 Short Problem Description**  
Julia has symptoms of depression that were triggered by a miscarriage (10 months ago), followed by her fiancé breaking up with her (8 months ago). She had to reduce her work hours because of her lack of energy. At home, she sleeps a lot but still feels drained. She reports feeling estranged from herself because she does not feel any emotions, just numbness. When her friend, Helen, who comes and picks her up to go to work, had to remind her to shower for work, Julia realized that she needs help. Her aim is to get on and reengage with life.  
  
**2 Goal Formulation**  
In the ideal situation, Julia will feel energetic and confident again. She will work full-time and enjoy her position as teaching assistant – especially the interaction with the children. She will contribute to the teaching plans with her own ideas for the music lessons, and write her own songs for the class. Also, she wants to give back to Helen. She knows that Helen has problems of her own and she wants to support her, just as Helen has supported Julia. She will also open herself up to different experiences and people; she will try out new hobbies such as joining a choir or learning to dance. She rates this scenario as the ideal situation (10 on the scale of 10 [ideal] to 0 [the opposite]).

As a result of therapy, Julia wishes to improve her situation to a 7,5 out of 10. At a 7,5, she will work 6 hours a day and have enough energy left to engage in pleasant activities. She will experiment with music and feel inspired by new songs she hears. She will be baby-sitting Helen’s children twice a month, and she will feel confident in her ability to make further progress by herself.

**3 Better moments / exceptions to problems**  
A couple of weeks ago, a colleague at work complimented her on one of the songs she wrote for the class last year. He asked whether he might be able to use it for the end of year theatre performance. This made her feel proud and accomplished.

Last week, one of the children in her class came to sit on her lap and gave her a hug, out of nowhere. Even though the feeling was very fleeting, unexpectedly connecting with the child and feeling its innocence and warmth made her feel slightly cheerful.

When asked to identify better moments, Julia notices that she feels slightly better and more energetic when she takes care of her rabbit in the evenings. She enjoys stroking its soft fur, with the rabbit’s long whiskers tickling her cheek as it sniffs her face. When the rabbit closes its eyes and snuggles up closer to her, she gets a sense of being wanted and needed.  
  
**4 Scaling of Improvement**  
Julia currently positions her situation at a 3 on the scale of 10 (ideal) to 0 (the opposite). Helen and her consistent support play an important role in preventing her from feeling any worse. With the help from Helen, Julia feels like she has been able to preserve a small reserve of strength, which has kept her going in the last couple of months. The love for her job is also a motivator; she knows that her job can make her happy and recognizes how lucky she is to have it.

For Julia, the next sign of improvement will be returning to work for one additional hour per day. Previously, her work has always invigorated and inspired her. She will ask whether she can teach the youngest class of children in this extra hour, because this is the age group she likes best, and feels that she is best at connecting with.

1. **Examples of problem-focused vignettes**

**Dean McCoy, male, 28 years old, train conductor.**  
   
**Anamnesis of the current complaints:**  
Dean was referred by his medical officer due to complaints that resembled a depressive episode. He has been on sick leave for three and a half weeks because he is not able to function at work. His problems at work began when his superior noticed that he was very inattentive and absentminded. After an incident where the railroad switches were passed over too late and Dean did not halt the train soon enough, his superior gave him a warning. Also, Dean has had some conflicts with co-workers, because they were “getting on his nerves” and he could not refrain from reacting. His supervisor told him about his concerns regarding the client’s (mental) health, and advised him to visit the railway medical officer. The medical officer worried about his behavior at work, as well as other problems that Dean reported he was experiencing outside of work.

Dean believes the problems started 2 months ago, when his girlfriend cheated on him and he left her. Simple things such as buying groceries, doing sports, and running errands started to take up all of his energy. He felt very empty, ashamed, and disappointed in life. They had been together for seven years and were planning to start a family. He thought that she loved him, but “clearly this was always just a show, and I fell for it”. The client is afraid that he will not be able to find or trust someone else. On top of that, he does not have the energy to go out and meet new people. His fear for the future also causes feelings of anxiety that he has never experienced before. He notices this when he is in large crowds: he often feels a sudden impulse to get away from all the noise and crowdedness.

Dean explains that in the few weeks before he went on sick leave, he started to stay home all on weekdays after his shifts. During weekends, he sometimes still visited his parents. Since he is on sick leave, he prefers to stay inside and reports spending most of his time watching TV or sleeping. It feels like nothing is truly important to him currently. He mentions that the thought has crossed his mind that he may be better off not living anymore, but reports not to have concrete plans. Dean would like to feel good again and not feel so alone.  
  
**Relevant Developmental Information:**  
Dean has a twin brother who lives in Australia and is currently trying to set up his own business. Their parents (John and Jenny McCoy) are still together and live 30 miles from Dean’s apartment. They are both retired, but his mother volunteers at a local refugee center. He remembers his childhood very positively: he was always together with his twin brother, and their family undertook many fun activities. They often went outside to play in the park, or had friends from school coming over. He still has a strong bond with both his father and mother, but he does not like to tell them much about his problems. He thinks that because his brother is so independent and “out there” living his life, his parents expect him to do just as well in life. Dean believes that he is not able to live up to such expectations: “I cannot keep either job or girlfriend”.  
  
**Medical History:**  
The client reports experiencing severe abdominal cramps since a few weeks. He has visited his GP because the pain would not subside with generic drugs (ibuprofen). No medical explanation was found however.  
**Psychiatric History:**  
Dean has never had a diagnosis of mental health problems, nor has he received treatment.

**Julia Keller, female, 29 years, assistant teacher.**  
   
**Anamnesis of the Current Complaints:**  
Julia reports a loss of emotions and feeling absolutely drained since about 8 months. 10 months ago, she had a miscarriage, and her fiancé broke up with her shortly after. She has difficulties getting up in the morning even though she sleeps a lot. She has reduced her hours at work because of lack of energy. She currently works 3 days a week and these days are always a struggle. On the days that she does not work, she naps throughout the day, but never feels well rested and feels like her energy is continuously drained, even though she tries to preserve as much energy as possible. She has gained 10 kg in the past 8 months and feels disgusted by her weight gain but reports that she no longer has the motivation to fight against it. Her fiancé broke up with her 8 months ago. She still has bridal magazines in her living-room. Sometimes she reads them to try and make herself cry, but she just feels numb and very distant from everybody. She has one good friend who makes an effort but Julia feels like she is pushing her friend away and believes that she is unworthy and does not deserve a friend. Julia would like to stop feeling so tired and numb, and be able to participate in life again.

**Relevant Developmental Data:**  
Julia grew up with her parents. They had struggled to conceive and did not have her, an only child, until they were both in their 40s. Her father died of prostate cancer 5 years ago and her mother lives with her new partner in the United States. They are not very close, but they telephone every couple of weeks and are not estranged. Julia remembers being embarrassed by her parents for being so much older than those of her peers. Although she was never particularly good at school, she had friends and enjoyed her musical hobbies. She describes herself as a somewhat introverted person who values culture and is helpful and reliable.

In high-school she met her ex-fiancé, and they were together for almost 10 years. They studied at University together and moved in soon after. When she got pregnant he proposed to her. They had planned to marry after the birth. But when Julia experienced a miscarriage in the fifth month of pregnancy her fiancé left soon after, explaining that he was unwilling to settle down for the life that they had created and that the loss of the baby gave him his chance to start over. Julia did not have many friends, having spent most of her time with her fiancé and his friends, so she was left dealing with the loss of the child and the relationship largely on her own.  
   
**Medical History:**  
Outside the miscarriage, Julia has only been hospitalized once for a broken arm in childhood and is not aware of any hereditary diseases in her family history.  
   
**Psychiatric History:**  
Julia is unaware of any family psychiatric history and has not been to a therapist before.