

A selected review of research of solution-focused brief therapy
by A. Jay McKeel

Abstract

This review examines research studies of solution-focused brief therapy (SFBT).

This body of research shows the model is effective and that techniques of the model accomplish their intended purpose. Findings and conclusions of existing studies are presented.

Ideas for additional studies of SFBT and some issues that researchers may consider in future research of SFBT are offered.

This article updates my research review (McKeel, 1996) that appeared in the Handbook of solution-focused brief therapy by Scott Miller, Mark Hubble, and Barry Duncan (editors) published by Jossey-Bass in 1996.

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research of solution-focused brief therapy
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Useful research addresses the needs and interests of the many consumers of research studies, including clinicians, clients, educators, students, theorists, third-party payers of psychological services, and health maintenance organizations (HMOs). Research of solution-focused brief therapy (SFBT) presented in this review concludes that the model is effective and that many techniques of the model accomplish their intended purpose. This article also provides a summary of studies that describe how clients describe their experience of SFBT.

Unfortunately, many research consumers will decide that the research of SFBT does not meet their needs. Few outcome studies of SFBT use experimental, quantitative outcome research that can provide some readers with convincing results, and few studies compare SFBT with other therapeutic models. Studies of SFBT techniques can ask more useful questions and use multiple measures to investigate the effectiveness of the interventions. More research asking clients about their experience of SFBT and specific techniques would be welcomed by many clinicians and research consumers.

This review has four parts. First is a review of outcome studies of SFBT. Next, investigations of SFBT techniques are presented. The third section describes information from and about clients about their experience of SFBT. The last section offers ideas for new research of SFBT. Finally, this article offers suggestions for investigating SFBT that many research consumers will find more useful.

Outcome Studies

Outcome studies address questions such as, "Is this therapeutic approach or model effective?" "If this model is effective, then when and with whom?" "Is this model better than other therapeutic approaches?" Existing outcome studies of SFBT have rarely used comparison groups, random assignment to treatment conditions, or strong and varied outcome measures. This limits the confidence that therapists and other research consumers will have in the findings and conclusions of this body of research.

Is brief therapy effective?

A large body of clinical research shows that brief therapy is an effective approach for most clients, including clients with severe and chronic problems. Studies comparing brief therapies with longer-term therapies show no difference in success rates between the two approaches (see Koss & Shiang, 1994, for a comprehensive review of research about brief therapies).

Interestingly, most clients begin therapy expecting it to be brief (Garfield, 1994; Koss & Shiang, 1994). Therapists, on the other hand, tend to prefer longer-term therapy (Warner, 1996; Pekarik, 1991).

Is SFBT effective?

In a study conducted at BFTC, Kiser (1988) and Kiser & Nunnally (1990) report an 80% success rate in a six-month follow up of clients receiving SFBT. [The researchers reached the 80% success rate by combining clients who reported they met their goal (65.6%) and those who reported significant improvement (14.7%).] A more recent study completed at BFTC, in which the researchers conducted seven to nine month follow-ups of 141 clients who received SFBT, reports a 77% success rate (De Jong & Berg, 1998). [This success rate was calculated by combining clients who met their goal (45%) and those who made some progress (32%).] In another study of SFBT, Lee (1997) reported a 64.9% success rate in a six-month follow-up [54.4% met their goals and 10.5% partly met their treatment goals]. Macdonald (1994; 1997) found success rates of 70% at a one-year follow-up and 64% after three years. Together these studies present consistent evidence that SFBT is effective.

Research also suggests that SFBT is an effective treatment for a broad range of client problems. De Jong and Berg (1998) report SFBT accomplished 70% or better success rates for many clinical problems, including depression, suicidal thoughts, sleep problems, eating disorders, parent-child conflict, marital/relationship problems, sexual problems, sexual abuse, family violence, and self-esteem problems.

Other research studies have examined the effectiveness of SFBT with specific client populations. For example, de Shazer & Isebaert (1997) report a 74% success rate for 250 inpatient clients and a 73.5% success rate for 72 outpatient clients with alcohol problems. An outcome study by Eakes, Walsh, Markowski, Cain, & Swanson (1997) found SFBT successful in treating five clients with a diagnosis of schizophrenia.

Three research studies have examined whether SFBT is effective in group therapy. These studies conclude that SFBT group therapy successfully addresses couples issues (Zimmerman, Prest, & Wetzel, 1997), parenting issues (Zimmerman, Jacobson, MacIntyre, & Watson, 1996), and anger reduction (Schorr, 1997).

Other research studies have found that SFBT is effective in an Occupation Therapy setting (Cockburn, Thomas, & Cockburn, 1997), in schools (Lafountain, Garner, & Eliason, 1996; Littrell, Malia, & Vanderwood, 1995), in Social Work Agencies (Sudman, 1997), and in prisons (Lindforss & Magnusson, 1997).

Is SFBT brief?

In a study of 275 cases receiving SFBT, De Jong and Berg (1998) report that the average number of sessions was 2.9. Clients in the Macdonald (1994) study attended an average of 3.84 sessions. de Shazer and Isebaert (1997), reporting on an outpatient SFBT treatment program for problem drinking, report clients attended an average of 4.6 sessions. Johnson & Shaha's (1996) study reports the average number of sessions of clients receiving SFBT was 4.77. Lee (1997) reports the average number of sessions of 59 families who received SFBT was 5.5.

The number of sessions of SFBT that a client attends and whether that client accomplishes their treatment goals seem related. In Macdonald's (1994) follow-up study, clients who reported a good outcome had an average of 5.47 sessions, while those who reported their

situation was the same or worse than before therapy attended an average of 2.67 sessions. Another study found that clients who received three sessions or less of SFBT had a success rate of 69.4% while clients attending four or more sessions had a success rate of 91.1% (Kiser, 1988; Kiser & Nunnally, 1990).

Is SFBT better than other therapy models?

Three studies comparing SFBT with other treatment models report that SFBT accomplishes equal or superior outcome results in an Occupational Therapy Setting (Cockburn, Thomas, & Cockburn, 1997), prisons (Lindforss & Magnusson, 1997) and schools (Littrell, Malia, & Vanderwood, 1995). These studies use stronger research designs by comparing SFBT with an existing treatment, randomly assigned clients to treatment conditions, and using more established outcome measures. No comparative outcome study has investigated SFBT in a traditional outpatient therapy setting.

The Lindforss & Magnusson (1997) is a good model for comparative outcome studies. Sixty prisoners were randomly assigned to receive either SFBT or the existing treatment (control group) provided to inmates. The outcome measure was re-arrest (recidivism) during two follow-up periods: 12 months after the inmate was released and again at 18 months. At 18 months, 40% of the inmates who received SFBT had not been re-arrested while only 14% of the control group had not been re-arrested, which was a statistically significant difference. The SFBT group had fewer arrests in the 18 months following their release from prison (86 vs. 153) and the SFBT group spent less time in prison for those arrests (86 vs. 136).

Consumers of the Lindforss & Magnusson (1997) research include prison administrators and clinicians who work with prisoners. These investigators compared SFBT with a treatment that these consumers were already using; without this comparison, these clinicians and administrators would have no convincing evidence that SFBT produced better results. Also, the investigators selected an outcome measure that is meaningful to these consumers: recidivism. This type of research design and outcome measures produces results that will interest research consumers and lead to improvements in services therapists provide.

SFBT Techniques

Solution talk

de Shazer (1988; 1994) encourages therapists to use change-talk or solution-talk. Examples of solution-talk include the therapist asking about pretreatment improvements, noticing differences between problem and non-problem times, expressing optimism that the client's situation will improve, and exploring action that the client can take to accomplish their goals.

Early in the development of SFBT the Milwaukee team used research to discover that when therapists use solution-talk, clients usually respond by talking about improvements in their situation or view of their situation (Gingerich, de Shazer, and Weiner-Davis, 1988). This study revealed the BFTC team rarely used solution-talk early in their first sessions; because of this research project de Shazer and the team to begin asking about change earlier in the first session.

Another study found that the more a client uses solution-talk in his/her first session, the more likely the client is to continue their therapy. Also, the more clients talk about

solutions or goals in their first session, the more likely they are to complete treatment rather than drop out (Shields, Sprenkle, and Constantine, 1991).

Pretreatment improvement

During a first session, solution-focused therapists usually ask clients what improvement in their problem have occurred since their call to request therapy (de Shazer, 1985; 1988). If the client reports any improvement, the therapist and client explore what the client(s) did to accomplish that improvement. Exploring pretreatment improvements may also help clients identify steps to take to continue helping their situation. Identifying pretreatment changes may lead clients to feel encouragement because they realize their situation can improve.

Research shows that pretreatment improvement is common. Allgood, Parham, Salts, & Smith (1995) found that 30% of 200 clients reported pretreatment improvement in the situation that led them to seek therapy. A study reviewing data from 2400 clients found that 15% made significant improvement before attending their first session (Howard, Kopta, Krause, & Orlinsky, 1986).

How does pretreatment change affect the process and outcome of therapy? One study found that clients who report pretreatment change are four times more likely to complete therapy than clients who report no pretreatment change (Johnson, Nelson, & Allgood, 1998). Additional studies about pretreatment improvements could ask: What differences exist between clients who do and do not report pretreatment change? Are clients who report pretreatment change more optimistic about accomplishing their goals? Do clients believe doing more of what led to pretreatment improvement will help them accomplish their treatment goals?

Presuppositional questions

Presuppositional questions are leading questions that communicate a belief or expectation. O'Hanlon and Weiner-Davis (1988) recommend to therapists: "...instead of, 'Did you ever do anything that worked?' ask, 'What have you done in the past that worked?'... The latter [question] suggests that inevitably there have been successful past solutions." (p. 80). Solution-focused therapists use presuppositional questions as interventions to help clients recall and discuss information about their strengths, abilities, and successes.

Studies show that clients are more likely to report pretreatment improvements when asked presuppositional questions. Weiner-Davis, de Shazer, and Gingerich (1987) asked clients in their first session, "Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed about your situation?" (p. 360). This question presupposes pretreatment improvement has occurred. Twenty of the thirty clients asked the question reported pretreatment improvements and gave specific examples regarding the problems that led them to seek therapy.

Replications of this study also found that more than 60% of clients who were asked a similar question by their therapist in their first session identified something about their problem that was better (Lawson, 1994; McKeel & Weiner-Davis, 1995). Johnson, Nelson, & Allgood (1998) asked clients a presuppositional question about pretreatment improvement in a written questionnaire completed before the beginning therapy and 53% of these clients reported pretreatment change.

Future research of presuppositional questions may explore issues other than pretreatment change. For instance, does a presuppositional question at the beginning of the second or subsequent session (e.g., "So, what has been better since I saw you last?") increase clients' reports of between-session improvement? Other research could explore if and how presuppositional questions lead clients to develop new views about themselves and their situation.

Miracle question

In the first session of SFBT, therapists usually ask clients the miracle question. The therapist asks,

Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different? . . . What will you notice different the next morning that will tell you that there has been a miracle? What will your spouse notice?" (de Shazer, 1991, p. 113).

In a qualitative study of the miracle question, twelve volunteers from a parental support group completed a one hour interview in which they were asked the miracle question. All twelve provided answers to the question. Some answers were realistic while others were idealized. These participants gave three categories of answers to the miracle question: concrete (e.g., a better home to live in), relational (e.g., closer relationships with loved ones), and affective/emotional (e.g., happier). After answering the miracle question, most participants felt more hopeful about their situation (Dine, 1995).

In a study of clients receiving SFBT, clients explained that the miracle question helped them focus on their goals for treatment and helped them focus on doing something different to accomplish their goals. These clients also felt more hopeful about their situation after answering the question (Shilts, Rambo, & Hernandez, 1997).

In a study of SFBT couples' therapy, researchers interviewed clients at the end of treatment to find out if they remembered their therapist asking the miracle question. Most clients did, but few could remember how they answered. Clients were more likely to recall their spouse's answer than their own (Odel, Butler, & Dilman, 1997).

Nau (1997) observed experienced SFBT therapists conducting first sessions and discovered two factors important in effectively asking the miracle question. First, the therapist must clearly join with the client before asking the question. Second, the technique is more effective if the therapist explores exceptions with the client before asking the miracle question.

Formula First Session Task

de Shazer and Molnar (1984) explain that the Formula First Session Task (FFST) is the homework assignment that SFBT therapists typically give clients to complete between their first and second session. The FFST asks clients: "Between now and the next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your (family, life, marriage, relationship) that you want to continue to have happen" (de Shazer,

1985, p. 137). One goal of using the FFST is to promote optimism by suggesting to a client that positive things will happen. Clients responding to the FFST in the second session often report new, positive steps that they have taken in their lives (de Shazer, 1985).

One study found that in their second session, 89 percent of the clients assigned the FFST reported that something positive and worthwhile had occurred since their first session and 57% reported that their situation was better (de Shazer, 1985).

Adams, Piercy, and Jurich (1991) compared a SFBT first session, which included assigning the FFST, with a problem-focused first session using a problem-focused first session task. At the beginning of their second session, the therapist followed up on the task. Clients assigned the FFST were more likely to have completed the task, more clear about their treatment goals, and more likely to report improvement in their presenting problem. However, clients assigned the FFST were not more optimistic about accomplishing their goals in therapy.

Jordan and Quinn (1994) also compared the FFST with a problem-focused first session task. In the second session, clients assigned the FFST were more likely to report improvements in their problem, more likely to expect their therapy would be successful, and more likely to rate their first session as productive and positive.

Therapists' views of SFBT techniques

Skidmore (1993) surveyed graduates from three SFBT training programs to assess their views of scaling questions, exception questions, miracle questions, and pretreatment change questions. Miracle questions and pretreatment change questions are described above. With scaling questions, SFBT therapists ask a client to rank his/her problem, perception, motivation, prediction, or any clinically relevant issue on a scale of one to ten (de Shazer, 1994). Therapists ask clients exception questions to identify when the problem was less severe or did not exist and what the client did to accomplish this (O'Hanlon & Weiner-Davis, 1989).

Of these four SFBT questions, therapists rated the miracle question as the most therapeutic. Scaling questions were the most frequently used and therapists rated these questions as the best way to evaluate a client's progress. Therapists described exception questions as typically leading a client to report exceptions and improvements in his/her problems and to describe what he/she did to achieve the change. Therapists rated questions about pretreatment changes as the least effective of the questions and the most difficult to use successfully (Skidmore, 1993).

Clients

Client-therapist relationship

Clients usually find SFBT useful. Clients appreciate the questions their therapists ask in SFBT. They find the SFBT focus on strengths, noticing differences, focusing on what works, and the positive atmosphere of their therapy to be useful (Beyebach, Morejon, Palenzuela, & Rodriguez-Aries, 1996; Metcalf, Thomas, Duncan, Miller, & Hubble, 1996; Shilts, Filippino & Nau, 1994).

When evaluating SFBT, clients explain that their relationship with their therapist is more

important than any specific technique their therapist uses. "[T]hey appreciate those therapists who are respectful and take the time to 'listen' to the families' story. Families consistently report that therapy appears most beneficial when the therapist appears caring and concerned" (Shilts, Rambo, & Hernandez, 1997, p. 129).

On the other hand, clients are critical of SFBT when they do not develop a close relationship with their therapist or do not feel heard and understood. One client noted, "We just never connected . . . he never understood our situation" and another client explained, "We were in the middle of a huge crisis and I don't think he picked up on it" (Odel, Butler, & Dielman, 1997). In their study of SFBT couples' therapy, Odell, Butler, and Dielman (1997) found that "when one member of the couple felt a lack of connection [with their therapist], therapy was over."

Dropouts

Beyebach & Carranza (1997) compared clients who dropped out of SFBT with those who completed therapy. The researchers described clients who dropped out as more conflictive and domineering in their session than clients who completed therapy. The researchers concluded that when therapists are supportive and respectful in SFBT, clients are more likely to complete treatment.

Gender

Jordan and Quinn (1997) compared males' and females' reactions to SFBT after two sessions. No significant difference was found between men and women regarding four variables: outcome optimism, self-efficacy, outcome expectancy, and session positivity. In their six-month follow-up outcome study of 141 clients who received SFBT, De Jong and Berg (1998) found no significant difference between men and women regarding treatment success.

The Next Step in Researching SFBT

Well designed and relevant clinical studies can benefit therapists, clients, theorists, educators and trainers, students and trainees, third-party payers, HMOs, and other consumers of research. Researchers who use different research methods, samples, data, and analysis will attract the interest of different audiences. For instance, an HMO may be interested in quantitative outcome studies of SFBT while some therapists will be more interested in qualitative studies that describe the effective use of SFBT questions. Future studies must continue to explore many research questions and use multiple research methods that meet the interest of varied research consumers.

This section suggests strategies researchers can use to address the needs of some SFBT research consumers. Third party payers of psychological services, trainers and educators, and many clinicians want results that well-designed quantitative outcome studies of SFBT provide. Clinicians who want practical and easy-to-gather information about improving services to their clients can use simple qualitative studies to meet their needs.

Experimental quantitative outcome research

Experimental quantitative outcome research using established measures is noticeably absent from SFBT research. Both clinicians and researchers have long valued this type of research as "an essential activity and as the type of research that has the largest impact on

practice" (Schwartz & Breunlin, 1983, p. 25). In this age of HMOs and therapist accountability, such research would enhance the credibility of SFBT. When conducting quantitative outcome research of SFBT, investigators should address the following issues.

Define SFBT. Existing outcome studies of SFBT typically fail to provide basic information about the model practiced by the therapists in the study. de Shazer and Berg (1997) urge researchers to "demonstrate that the model of therapy being tested is indeed the model used by the therapists [in the research study]. Otherwise any and all findings are suspect." (p. 123).

However, a rigid protocol of SFBT in research studies conflicts with the "do what works; if it does not work, do something different" philosophy of the model. To remedy this, studies of SFBT can encourage therapists to do what they consider is best for their clients. After treatment is finished, the investigator can review the case to determine if it meets the criteria for inclusion in a study of SFBT. While this research strategy presents some methodological problems, it has three advantages: better representing how SFBT is actually practiced, allowing the investigator to discover if and when SFBT practitioners deviate from or abandon the model, and it best meet clients needs.

Design comparative studies. Future quantitative outcome research needs to randomly assign clients to two or more treatment conditions. Almost all existing research of SFBT has no comparison group, a design that Kerlinger (1986) deems scientifically worthless.

Past useful quantitative research has used several types of comparison groups. A comparative outcome strategy compares the model under examination (the experimental group) with an established model (the control group) to determine if the new model compares favorably or produces better results than the control model.

A dismantling outcome strategy compares two groups to learn what components of the model are necessary or sufficient for treatment success. For example, research could test the importance of SFBT homework assignments in treatment outcome; one group of clients would always be assigned SFBT homework while the other would be assigned either no homework or non-SFBT homework. A constructive outcome strategy could be used to test new techniques or ideas by conducting traditional SFBT with one group while the other group receives SFBT plus the new idea. Finally, outcome studies can compare two groups based on therapist characteristics; for instance, comparing a team approach to therapy conducted by an individual therapist or comparing experienced and novice therapists (Kazdin, 1994).

Researchers debate the merits and ethics of a no-treatment control group; that is, comparing a group of clients receiving treatment with clients who receive nothing. Some argue that this type comparison group is necessary to prove that a particular model produces therapeutic improvement by determining if people who call to request therapy may be as likely to resolve their problems without any clinical help (e.g., Kazdin, 1994).

Other researchers believe using a no-treatment control group is unnecessary and unethical (e.g., Todd & Stanton, 1983). These researchers argue that no-treatment groups are no longer necessary because a sufficient body of research shows that people are significantly more likely to improve their situation if they receive therapy. More importantly, denying

services may be unethical and even dangerous for many clients asking for therapy, especially when violence, suicidal thoughts, eating disorders, or substance abuse are problems.

Improve outcome measures. Some outcome studies of SFBT categorize clients who report they met "some goals" as treatment successes. Weak outcome criteria offer little information to practitioners or other consumers or audiences of research.

When researchers use multiple measures, they speak to the various consumers of research studies. Some therapists will be satisfied with relying only on clients' perceptions of their treatment while others will place more confidence in the results of a study that also includes success ratings from the therapist or other observer (this is especially true regarding the treatment of substance abuse or violence). Third-party providers may have more confidence in a model that demonstrates its effectiveness with traditional research measures and instruments.

The success of treatment can be measured in multiple ways. Client self reports can be global (my marriage is better), affective (I am happier), behavioral (we spend more time together), and cognitive (I do not worry about divorce now). Observational data can be collected from therapists and/or others (e.g., a team behind a mirror or an interviewer who meets with the client). Standardized tests are another important tools available for researchers wanting to demonstrate treatment success.

Franklin, Corcoran, Nowicki, and Streeter (1997) offer one method of collecting outcome data that may interest SFBT practitioners. Clients develop scales (0 = client fails to make any movement toward goals; 10 = client is completely satisfied). Johnson (personal communication) has also developed a method for tracking client progress based on a 1-10 rating scale which uses scaling to track clients' progress.

Variance between therapists. Research literature consistently demonstrates that some therapists are more effective than others. Future studies of SFBT should collect data about therapist characteristics, practice, and therapeutic philosophy to identify variances between therapists and to detect which variables relate to better success rates of more effective therapists. Understanding what more effective therapists do may contribute more useful information to clinicians than any other type of research results.

A simple qualitative study

Consistent with the philosophy of SFBT, simple research can also be good research. Here is a low cost, easy-to-do research study currently being conducted at Bowie Youth & Family Services. Clinicians and clients both find this questionnaire useful. We also expect it will also provide more general information about how clients use therapy to accomplish their goals.

Our agency asks clients to complete this questionnaire before their second and subsequent sessions. Clients report this questionnaire motivates them to take more action to change and appreciate that their therapist cares about their progress and what the client considers important to do in their sessions. It helps therapists better understand what our clients want from us. The questionnaire includes the following questions:

1. What was most useful about your last session?
2. What changes has your family made since your last session?
3. What can you and your therapist do today that will help you accomplish your goals?
4. How can therapy better meet your needs?

At the beginning of each session, clients give their questionnaire to their therapist who begins the sessions by responding to clients' answers.

After collecting enough responses, Bowie Youth & Family Services will review the answers to identify patterns or categories of responses. The categories the investigator develops would be guided by the answers clients gave to these questions, but examples of categories that might occur include: developing a plan of action, feeling support from the therapist, using therapy to make important decisions, and better understanding my spouse. The result can describe what clients find useful and what they want from therapy.

Clinical research should offer clinicians information that helps them better serve to their clients. Studies such as the Bowie project accomplish that goal in the short term (by providing relevant, on-the-spot information to the therapist about what the client has and will find useful) and in the long-term by reporting findings of this study to other therapists.

Conclusions

Outcome studies of SFBT show that the model is effective and prompts positive outcomes for most clients. SFBT is successful with most clients and produces positive outcomes for a variety of clinical problems and in a variety of settings. However, a serious omission from this body of research is well-designed quantitative experimental outcome research. Such studies would promote stronger confidence in the effectiveness of SFBT.

Studies of SFBT techniques have found that: (a) when therapists use solution-talk, their clients are more likely to talk about change. The more clients use solution-talk, the more likely they are to complete their therapy. (b) Pretreatment improvement is common. (c) Presuppositional questions usually accomplish their goal of helping clients notice strengths, improvements, and past successes. (d) The miracle question can help clients focus on their treatment goals and feel more optimistic about their situation. (e) Clients usually complete the FFST and report improvements when assigned that homework. (f) SFBT therapists frequently use scaling questions.

(g) SFBT therapists report that exception questions typically prompt clients to talk about exceptions and improvements regarding their problems. (h) Therapist find questions about pretreatment change to be the most difficult to use effectively.

This body of research also tells us that focusing solely on techniques misses one key to successful SFBT: the client-therapist relationship. The study by Odell, Butler, and Dielman (1997) highlights this: although therapists were asking the miracle question, assigning the

FFST, and using other SFBT techniques, if a client did not feel their therapist heard and understood them, they left therapy. Studies of the perceptions of clients highlight the importance of therapists' relationship with their clients and that SFBT is successful when it is both solution-oriented and client-oriented.

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