

# Solution-Focused Brief Therapy: A Review of the Outcome Research\*

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*Solution-focused brief therapy (SFBT) is a new and increasingly used therapeutic approach that focuses on helping clients construct solutions rather than solve problems. The approach evolved in a clinical context amid many anecdotal reports of success from both therapists and clients, but it has not been subjected to controlled empirical testing until very recently. In this article we critically review all of the controlled outcome studies of SFBT to date (N = 15) to assess the extent to which SFBT has received empirical support. Five studies were well-controlled and all showed positive outcomes—four found SFBT to be better than no treatment or standard institutional services, and one found SFBT to be comparable to a known intervention: Interpersonal Psychotherapy for Depression (IPT). Findings from the remaining 10 studies, which we consider moderately or poorly controlled, were consistent with a hypothesis of SFBT effectiveness. We conclude that the 15 studies provide preliminary support for the efficacy of SFBT but do not permit a definitive conclusion. Our*

*critique highlights areas where methodology in future studies can be strengthened to provide more conclusive evidence of SFBT efficacy.*

*Fam Proc 39:477–498, 2000*

IN less than two decades, solution-focused brief therapy (SFBT) has grown from a little-known and unconventional therapeutic approach to one that is now widely used in the United States and, increasingly, in other countries. SFBT is used in family service and mental health settings, in public social services and child welfare, in prisons and residential treatment centers, in schools and hospitals (Miller, Hubble, & Duncan, 1996). Enthusiastic practitioners report successful outcomes and high client satisfaction using SFBT. Insurers and governmental funders have increasingly embraced SFBT because it is short-term and therefore relatively inexpensive.

But widespread use and anecdotal reports of success do not provide an adequate basis for the ongoing use of SFBT, or any therapeutic approach. What is needed is objective, empirical evidence of the effectiveness of SFBT—evidence that clients are better off in demonstrable and meaningful ways as a result of intervention. Accordingly, we decided to conduct a comprehensive review of the available out-

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come research to see to what extent there is empirical support for the effectiveness of SFBT. We begin by providing a brief description of SFBT and early attempts to document SFBT outcomes. Then we critically review controlled studies of SFBT outcomes that have appeared in the literature through 1999—fifteen studies in all. Based on our review, we discuss the extent to which SFBT has received empirical support and conclude with recommendations for the kind of additional research that is needed to establish SFBT clearly as an empirically supported treatment.

### SFBT Origins

SFBT evolved out of the clinical practice of Steve de Shazer, Insoo Kim Berg, and colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin, in the early 1980s (de Shazer, 1982, 1985, 1988; de Shazer, Berg, Lipchik, et al., 1986). As the name suggests, SFBT is defined by its emphasis on constructing solutions rather than resolving problems. The main therapeutic task is helping the client to imagine how he or she would like things to be different and what it will take to make that happen. Little attention is paid to diagnosis, history taking, or exploration of the problem. Solution-focused therapists assume clients want to change, have the capacity to envision change, and are doing their best to make change happen. Further, solution-focused therapists assume that the solution, or at least part of it, is probably already happening (Weiner-Davis, de Shazer, & Gingerich, 1987). Treatment is brief, usually lasting less than six sessions.

Over the years, de Shazer, Berg, and colleagues developed a number of specific techniques to aid in solution-focused intervention. The best known of these is the *miracle question*, which asks the client to pretend that a miracle has happened and imagine a solution to the problem (DeJong & Berg, 1998; de Shazer, 1988). A second

technique routinely used is the *scaling question*, which asks the client to rate on a 10-point scale how things are today. Both of these techniques are used to aid in the construction of the solution and the search for parts of the solution that may already be happening. SFBT typically includes a "consulting break" toward the end of the session in which the therapist constructs a message that includes compliments for the client and a homework task.

### Early Followup Studies

As the solution-focused model was evolving, the team at the Brief Family Therapy Center conducted followup surveys of clients to determine whether clients were benefiting from the new approach. Treatment outcome was measured by asking clients at 6–18 months followup to indicate if they had met their goals for therapy or felt that significant progress had been made. In the first such study, de Shazer (1985) reported an 82% success rate on followup of 28 clients. The next year, de Shazer et al. (1986) reported a 72% success rate with a 25% sample of 1,600 cases. Subsequent studies have reported similar results (DeJong & Hopwood, 1996; Kiser, 1988). The data from these studies compare favorably with those reported earlier by Weakland, Fisch, Watzlawick, and Bodin (1974) who followed up brief therapy clients in Palo Alto.

Several clinician-researchers outside the Milwaukee group have also conducted followup studies of SFBT (Lee, 1997; Macdonald, 1997; Morrison, Olivos, Dominguez, et al., 1993; Schorr, 1997). For the most part, these studies also used subjective outcome measures and found similar but somewhat smaller success rates. Schorr (1997), however, employed a pre-post design with the State-Trait Anger Inventory as the outcome measure, and found that after 8 group sessions the percentage of

members scoring in the clinical range had declined from 67% to 40%.

While these followup studies provided important early feedback on SFBT outcomes, their lack of experimental control does not permit causal inferences to be made about the effectiveness of SFBT. Recently, however, controlled studies of SFBT outcomes have begun to appear in the literature, and they are of primary interest in our review.

### REVIEW METHODOLOGY

We decided to review all of the controlled studies of SFBT client outcomes appearing in the English literature up to and including 1999. By *controlled studies*, we mean studies that employed some degree of experimental control, that is, used a comparison group or single-case repeated-measures design. By *client outcomes*, we mean client behavior or functioning—we excluded studies that reported only client satisfaction. Finally, we limited our review to studies that reported *end-of-treatment* or later outcomes. This ruled out studies that examined intermediate therapy outcomes, such as the impact of the Formula First Session Task on the second session (Adams, Piercy, & Jurich, 1991). Finally, we excluded ethnographic and change process studies (Beyebach, Morejon, Palenzuela, & Rodriguez-Arias, 1996), since, by definition, they did not assess end-of-treatment outcomes.

We identified the domain of potential outcome studies by first searching the PsychLIT, Social Work Abstracts, Psych-Info, Medline and Dissertation Abstracts bibliographic databases, selecting studies that used the terms "solution-focused" or "solution-oriented" and "outcome research" in their titles or abstracts. We augmented this by searching the World Wide Web on the same terms. We also reviewed a listing of published outcome studies compiled by

Alasdair Macdonald, Research Coordinator of the European Brief Therapy Association (Macdonald, 1998a). Finally, we consulted several reviews of SFBT research (DeJong & Hopwood, 1996; Franklin & Jordan, 1999), as well as the bibliographies of each of the outcome studies we included in our review.

To be considered a study of *solution-focused* brief therapy, the intervention had to be identified by the study's author(s) as solution-focused or solution-oriented as developed by de Shazer and colleagues at the Milwaukee Brief Family Therapy Center (de Shazer & Berg, 1997; Macdonald, 1998b). Operationally, this meant the intervention had to include one or more of the following core components: (1) a search for pre-session change, (2) goal-setting, (3) use of the miracle question, (4) use of scaling questions, (5) a search for exceptions, (6) a consulting break, and (7) a message including compliments and task.

The final selection of studies was made after we independently reviewed each potential study and then together agreed that the study

- implemented solution-focused brief therapy,
- employed some form of experimental control,
- assessed client behavior or functioning, and
- assessed end-of-treatment outcomes.

Our search located 15 controlled studies of SFBT outcomes appearing in the literature through 1999. We were guided in our critique of the 15 studies by standards for assessing empirical support for psychological treatments developed by the American Psychological Association (Task Force on Promotion and Dissemination of Psychological Procedures, 1995) and modified by Chambless and Hollon (1996). In brief, these standards require studies to (1) use a randomized group design or acceptable

single-case design; (2) focus on a specific, well-defined disorder; (3) compare the experimental treatment with a standard reference treatment, a placebo or, less desirably, no treatment; (4) use treatment manuals and procedures for monitoring treatment adherence; (5) use outcome measures with demonstrated reliability and validity; and (6) use a sample large enough to detect group differences reliably.

Based upon these standards we have divided the studies into three groups according to the degree of experimental control they employed: (1) five studies met 5 to 6 standards and we consider them well-controlled, (2) four studies met 4 of the standards, and we consider them moderately-controlled, (3) six studies met 3 or fewer standards and we consider them poorly-controlled. (See Tables 1, 2, and 3, below.)

### WELL-CONTROLLED STUDIES

#### Depression in College Students

Sundstrom (1993) was the first to design a randomized experimental study of SFBT using standardized outcome measures. She compared a single session of SFBT to a single session of Interpersonal Psychotherapy for Depression (IPT) for the treatment of depressed college students. The sample was comprised of 40 female undergraduate psychology students at a Midwestern university who scored in the mild to moderately-depressed range (10–29) on the Beck Depression Inventory. Thirty-four percent of the sample met diagnostic criteria for Major Depression according to the Inventory to Diagnose Depression.

Subjects were randomly assigned to the experimental or control group, and then given the battery of outcome measures. Measures included the Beck Depression Inventory (BDI), the Depression Adjective Checklists (DACL), the Rosenberg Self-Esteem Scale (SES), and the Counselor

Rating Form–Short Form (CRF-S). Treatment consisted of one 90-minute counseling session—SFBT for the treatment group and IPT for the comparison group. Sessions were conducted by 21 female counselors who were licensed social workers, licensed psychologists, psychology interns, or advanced psychology graduate students. To assure adherence to treatment protocols, clinicians participated in separate 2-hour training sessions for each condition, and all counseling sessions were videotaped and rated by research assistants who were blind to the treatment condition. A followup interview was conducted a week to 10 days after treatment, at which time subjects completed the BDI, DACL, SES, and CRF-S.

MANOVA analysis of pre- to post-intervention BDI and DACL scores showed both treatment conditions produced significant positive change, and that neither treatment produced significantly better outcomes than the other. SES scores revealed no change across time for either treatment condition. Lack of significant differences between treatments in CRF-S scores indicated counselor characteristics did not contribute differentially to treatment outcome.

Sundstrom's study satisfies most of the standards for demonstrating empirical support. She used a randomized control group design, studied a well-defined sample, compared SFBT with a standard reference treatment, used treatment manuals and monitored adherence, and used standardized outcome measures. It is not clear how the subjects (college students) were selected for the study; however, Sundstrom established that subjects were mild to moderately depressed and that many (one-third) met diagnostic criteria for major depression. Although Sundstrom found no significant differences between treatments, and no trend favoring one treatment over the other, the number of sub-

jects (20 per group) was too small to conclude reliably that the treatments were equivalent. Sundstrom's study demonstrated that single-session SFBT was effective in reducing depressed mood, and suggests that SFBT outcomes may be comparable to IPT, an empirically validated treatment for depression (Chambless, Sanderson, Shoham, et al., 1996). Uncertainty about the representativeness of the study sample makes it difficult to know to what clinical populations Sundstrom's findings may generalize (see Table 1).

### Parenting Skills

Zimmerman, Jacobsen, MacIntyre, and Watson (1996) evaluated the effects of a solution-focused parenting group on parenting skills and perceived family strengths. Parents experiencing difficulties with their adolescents' behavior were recruited through a newspaper advertisement and respondents were randomly assigned to an experimental ( $N = 30$ ) or wait-list control ( $N = 12$ ) group. All subjects completed the Parenting Skills Inventory (PSI), an 86-item self-report questionnaire with 7 subscales designed to measure parenting skills, and the Family Strengths Assessments (FSA), a 12-item measure of family happiness.

Five experimental parenting groups, each composed of 6–8 parents, met weekly for six 30-minute sessions. Graduate students in the Marriage and Family Therapy Program at Colorado State University facilitated the groups under faculty supervision. Direct comparisons of the post-test scores of the SFBT and wait-list groups revealed statistically significant ( $t$ -test) differences for the total PSI score and several PSI subscales: Role Image, Rapport, Communication, and Limit Setting. No statistically significant differences were found between groups for the FSA. Analysis of pre-post data for the SFBT group revealed statistically significant change

for the Role Image, Objectivity, Communication, and Limit Setting subscales of the PSI, and the FSA total score. In contrast, pre-post comparisons for the wait-list group showed significant change for only one subscale of the PSI: Role Support. The authors note that even though the SFBT group showed significant pre-post improvement on FSA scores, it was not significantly different from the wait-list group at post-test.

The use of a randomized pre-post design, treatment manual, and standardized outcome measures suggests that subjects benefited from the SFBT intervention. However, there are a number of considerations that qualify this conclusion. The small size (apparently due to high attrition) of the wait-list comparison group ( $N = 12$ ) makes it impossible to conclude reliably that the wait-list subjects did not also improve during the study, but, unfortunately, the authors do not address the issue of trend in the wait-list group. If by chance the subjects in the wait-list group did improve during the study, the efficacy of SFBT would be cast into doubt since, presumably, some third factor caused change in both groups.

A strength of the Zimmerman et al. (1996) study is that it targeted a specific population (parents experiencing adolescent conflict); however, subjects were self-selected, casting doubt on what populations the findings can be generalized to. Finally, comparison of SFBT subjects with wait-list ("no treatment") subjects does not control for attention effects that may go along with treatment, resulting in what Chambless and Hollon (1998) call a possibly efficacious but not specific treatment. In other words, although subjects appeared to benefit from the intervention, it cannot be determined that the benefit was due specifically to the SFBT intervention as opposed to the nonspecific effects that presumably accompany any intervention.

TABLE 1  
Well-Controlled Studies

	Sundstrom, 1993	Zimmerman et al., 1996	Cockburn et al., 1997	Lindforss et al., 1997	Seagram, 1997
<b>Subjects/ Problem</b>					
Setting	university	university clinic	orthopedic rehab.	prison	secure custody
Sample size	40	42	48	59	40
Problem	depression	parent-child conflict	orthopedic injury	recidivism	adolescent offenders
Select. criteria?	yes	no	yes	yes	yes
Demographics	all female ave age: 19	36% male; ave age: 41	58% male; ave. age: 37	all male	all male; age 16-19
<b>Intervention</b>					
# SFBT core conditions	5	4	3	4	7
Modality	individual	group	individual	network	individual
# sessions	1	6	6	1-12	10
Treat. manual?	yes	yes	yes	no	no
Monitored?	yes	no	no	no	yes
Therapist experience	varied; newly trained in SFBT	trainees; newly trained in SFBT	not reported	not reported	advanced student
<b>Design</b>					
Type	pre/post-test comparison group	pre/post-test control group	Solomon 4 group	post-test only control group	pre/post-test control group
Randomized?	yes	yes	yes	yes	matched
Comparison group	prob-focused; interpersonal therapy	wait-list	standard rehab treatment	standard institutional services	standard institutional services
<b>Outcomes/ Results</b>					
Measures used – end of treatment outcome	Beck Depr. Inv.; Depr. Adject. Checklist Rosenberg Self-Esteem Scale	Parenting Skills Inventory – sig. between group differences on 4 of 8 scales; Family Strengths Assess. – no sig. between group diffs.	F-COPES – sig. between group differences on all 5 scales; PAIS-R – sig between group differences on 4 of 5 scales	recidivism (new offense with return to probation or prison)	multiple (Jesness; Coopersmith; Carlson; SF Quest.) – tmt s's had sig. lower chem. abuse tend., higher empathy, greater prob. solving, higher optimism
Followup	7-10 days – both groups sig. improved on BDI and DAC; no sig. between group differences on any measures	none	7 & 60 days – 68% tmt s's vs. 4% control s's returned to work in less than 7 days	12 months – 53% tmt s's vs. 76% control s's recidivated; 16 months – 60% tmt vs. 86% control recidivated	6 months – 20% tmt vs. 42% control recidivated

### Rehabilitation of Orthopedic Patients

Cockburn, Thomas, and Cockburn (1997) evaluated the impact of SFBT on psychosocial adjustment and return to work for patients with orthopedic injuries. The study sample was comprised of 48 patients and their spouses, referred by an orthopedic surgeon to a rehab program designed to prepare patients for work re-entry. Subjects had to be first-time recipients of a worker's compensation claim, married to a spouse who is employed full-time, not currently on prescription drugs, and without other medical problems that could compromise the study. Seventy-three percent of the final sample had orthopedic injuries of the spine or upper extremities.

Subjects were randomly assigned to one of four groups, following a Solomon Four Groups design. The intervention for treatment groups 1 and 3 consisted of 6 weekly one-hour sessions of SFBT plus the standard rehab program. Treatment was implemented by the first author and followed a standard protocol (Jack Cockburn, personal communication, April 18, 1999). Control groups 2 and 4 received only the standard rehab program. Pre-test data were collected from treatment group 1 and control group 2 using the Family Crisis Oriented Personal Evaluation Scales (F-COPES). Post-test data were collected from all 4 groups using the F-COPES and the Psychosocial Adjustment to Illness Scale-Self-Report (PAIS-SR). Subjects' spouses also completed the PAIS-SR at post-test. Because pre-testing was shown to have a consistent effect across treatments, analyses were based on ANOVAs for the post-test data only.

Analysis of F-COPES data indicated significant between-groups differences on all 3 subscales used in the study. The two treatment groups were 9–13 points higher on Acquiring Social Support, 9–14 points higher on Reframing, 5–7 points higher on

Mobilizing Family, and 4–5 points higher on Seeking Spiritual Support than were the two control groups. Between-group differences on the PAIS-SR were also statistically significant. Couples in the treatment groups were about 4 points higher on the Health Care scale, 4 points higher on Domestic Environment, 9 points higher on Psychological Distress, and 5 points higher on Social Environment. There was no significant difference between groups on the Vocational Environment scores. The authors concluded that patients in the SFBT groups had significantly better psychosocial adjustment and social supports than patients in the control group. Within 7 days after completion of treatment, 68% of subjects in the treatment groups had returned to work as compared to only 4% of subjects in the control groups. By 30 days after treatment, 92% of the SFBT patients had returned to work as compared to 47% of control group patients.

This study employed a rigorous, randomized design, screened subjects according to well-defined eligibility criteria, used a treatment protocol, and used standardized outcome measures along with a measure of ultimate outcome (Rosen & Proctor, 1978)—return to work. Differences in return to work rates were of sufficient magnitude to have obvious clinical significance. Although the sample size was small (25 treatment subjects, 23 control subjects), it was sufficient to demonstrate that the SFBT group was significantly improved as compared to the standard treatment group. Since this study compared SFBT with the standard rehabilitation protocol (which presumably did not include individual counseling with patients), there is no control for attention effects; thus, we do not know to what degree SFBT effects were specific. However, the data clearly demonstrate that SFBT plus the standard rehabilitation

care was superior to standard care alone. This finding was most evident in increased return-to-work rates, the ultimate goal of rehabilitation programs such as this one.

### **Recidivism in a Prison Population**

Lindforss and Magnusson (1997) studied the effectiveness of a SFBT network intervention in reducing recidivism for prisoners incarcerated at Hageby Prison in Stockholm. This population consists of serious criminals with high recidivism rates, disciplinary problems, and long histories of drug abuse and contact with correctional and social welfare agencies. Prisoners who had 2–10 months left to serve and were willing to participate in the study were randomly assigned to a SFBT treatment group ( $N = 30$ ) or a control group ( $N = 30$ ). Treatment was provided by a team consisting of a project leader and two family therapists who were in private practice in Stockholm. Treatment lasted for 1–12 sessions, with an average of five sessions.

Recidivism, defined as committing an offense subsequent to release, which resulted in probation or reincarceration, was used as the outcome measure. Data were taken from central prison and probation records at 12 and 16 months after subjects were released from prison. At 12 months after release, prisoners in the treatment group had a recidivism rate of 53% compared to 76% for the control group. At 16 months, recidivism rates increased to 60% for the experimental group and 86% for the control group, and differences remained statistically significant. In addition, the seriousness of recidivist offenses and length of resulting sentences were less for the SFBT group than the control group. Finally, the authors note that the prisoners in the control group "incurred an expenditure of 2.7 million Swedish crowns more in prison costs than the experimental group during the followup

year" (Lindforss & Magnusson, 1997, p. 102).

This study is notable for its use of a well-defined and difficult to treat population, random assignment to groups, and use of an ultimate outcome measure—recidivism. Although arrest and adjudication data are subject to biases in criminal justice processing, they have obvious validity as a measure of ultimate outcome. Nevertheless, other standardized measures of behavior outcomes would have been useful in assessing treatment outcomes. Further, the study is limited by lack of a treatment manual or procedures for monitoring treatment implementation. Sample size, while not large, was adequate for detecting differences between the treatment and control groups. While it is unclear exactly what the SFBT network intervention consisted of in this study, it is evident that prisoners who received the treatment benefited in terms of lower recidivism rates. This is also one of very few studies that addressed directly or indirectly the issue of cost-benefit of SFBT intervention.

### **Antisocial Adolescent Offenders**

Seagram (1997) evaluated the efficacy of SFBT for improving attitudes and behaviors, and reducing antisocial thinking and behavior in adolescent offenders in a secure facility for youthful offenders. The study sample consisted of 40 youths who were rank-ordered according to sentence and then alternately assigned to the treatment ( $N = 21$ ) or control ( $N = 19$ ) group to insure comparability on seriousness of offence. Participants had to have a diagnosis of psychosis and a history of refusal to take medications to be eligible for the study. Eighty-five percent of the sample had a history of violent behavior, 90% were repeat offenders, and 65% were currently incarcerated for a violent crime.

All subjects attended a group orientation session and three individual assess-



ment sessions prior to the treatment participants beginning 10 weekly SFBT sessions. SFBT was offered in addition to the standard services provided by the institution. The author, a doctoral candidate at York University in Ontario, conducted the orientation, assessments, and treatment, with each SFBT session lasting 45–60 minutes. An external reviewer rated first and last sessions to insure adherence to the SFBT model.

Outcome measures included the Jesness Behavior Checklist Recidivism Scales, Achenbach Youth Self-Report, Carlson Psychological Survey, Coopersmith Self-Esteem Inventory, and a Solution-Focused Questionnaire developed by Seagram. The Jesness was completed by the youth, his correctional officer, and a teacher; the other measures were all self-report.

Scores on the Solution-Focused Questionnaire indicated that the treatment group made more progress in solving problems and had higher confidence in their ability to maintain changes than did the control group. Carlson Psychological Survey data indicated that the treatment group had significantly more optimism for the future, greater empathy, fewer antisocial tendencies, and less chemical abuse. Treatment group subjects showed significantly less difficulty with concentration (Achenbach). The Jesness and Coopersmith measures failed to show any significant between-group differences. Teacher ratings on the Jesness and Teacher Report Form showed trends favoring the SFBT subjects, but differences did not reach significance. Within a 6-month followup period, 4 (20%) members of the treatment group vs. 8 (42%) members of the control group had re-offended (run away or were moved from open to secure custody).

Seagram's study meets many of the criteria for demonstrating empirical support. A matching design was used (in lieu

of random assignment) to assess whether SFBT improves on the outcomes of standard institutional care; the study sample was well-defined; although a treatment manual was not used, treatment adherence in the first and last sessions was rated by an outside observer. Outcome measures included several widely used objective measures of behavior change. Although Seagram found some significant between-groups differences, and several trends in the expected direction, overall SFBT outcomes appeared modest. Finally, comparing SFBT with standard institutional (noncounseling) care did not allow for an estimation of the specific effect of SFBT.

## MODERATELY-CONTROLLED STUDIES

### Counseling High School Students

Littrell, Malia, and Vanderwood (1995) used a randomized post-test only design to examine the effects of three variants of single-session brief therapy on alleviating academic and personal concerns and increasing goal achievement of students at a large, urban high school. Sixty-one male and female students in grades 9–12 who sought appointments to discuss problems with their school guidance counselors were randomly assigned to one of three groups: problem-focused with a task, problem-focused without a task, and solution-focused with a task. All groups implemented two or more of the following four steps common to brief treatment: (1) define a problem, (2) identify previously attempted solutions, (3) set a specific goal, and (4) assign an intervention task. The two problem-focused groups (with and without task) implemented steps 1–4 or 1–3, respectively, whereas the solution-focused group (SFG) implemented only steps 3–4. Counselors received training in brief counseling methods and consulted treatment protocol sheets developed by the researchers.

Outcome data were collected at brief followup sessions 2 and 6 weeks after the initial counseling session. Students and counselors collaboratively rated student progress in three areas using 7-point Likert-type scales: alleviating concerns; moving toward goals; and decreasing of intensity of undesirable feelings, thoughts, and actions. All three models of therapy showed statistically significant improvement across all three areas of change between the 2-week and 6-week followups. However, no significant between-treatment effects were found (see Table 2).

Although this study reported positive outcomes, its internal validity is compromised by several methodological limitations. Most importantly, standardized outcome measures were not used and pretreatment measures were not administered. Although subjective ratings by counselors and clients have obvious face validity, they are subject to social desirability biases that may render them invalid as measures of actual client functioning. This, and the lack of pre-test data, prevents us from concluding that change occurred due to treatment. Further, relatively minor differences between the three therapy models make the study more a comparison of various components of brief therapy than a controlled test of SFBT itself.

### **Solution-Focused School Groups**

LaFountain and Garner (1996) investigated the impact of solution-focused groups (SFG) on school age children and school counselors. School counselors were recruited for a training program in SFG as an alternative approach to managing large caseloads with fewer resources. The final sample included 57 counselors randomly assigned to treatment and control groups who served a total of 311 elementary, middle, and high school students. Experimental group counselors attended a full-day SFG training workshop and were then asked to select 4–8 students

from their caseloads who met criteria for inclusion in SFG. Treatment consisted of 8 weekly SFG sessions. Control group counselors (who were told the purpose of the study) did not provide any type of group counseling to their students. They were asked instead to identify potential students for SFG intervention and administer pre- and post-measures only to those students.

The Index of Personality Characteristics (IPC), a 75-item questionnaire that measures child functioning, was administered prior to intervention and again 8 weeks later (at the completion of the intervention for SFG students). Modest but statistically significant between-group differences were found on 3 IPC subscales: Nonacademic, Perception of Self, and Acting In. According to the authors, these differences suggest that students in the experimental group had higher self-esteem in nonacademic arenas; more positive attitudes and feelings about themselves; and more appropriate ways of coping with emotions.

Because counselors (who were randomly assigned) knew the purpose of the study and selected the students to participate in the study, it is impossible to determine if student characteristics relevant to treatment outcome were randomly distributed between the groups. Further, this study occurred in a naturalistic setting and was not directed toward a specific diagnostic group, making it difficult to determine exactly what to what population the results might generalize. It did, however, use a treatment manual and standardized outcome measure. Although the data indicate that SFG subjects benefited, it is difficult to know to what extent the results are due to the intervention as opposed to some other factor such as selective assignment to groups or counselor expectations.

TABLE 2  
Moderately-Controlled Studies

	Littrell et al., 1995	LaFountain et al., 1996	Triantafillou, 1997	Zimmerman et al., 1997
<b>Subjects/ Problem</b>				
Setting	high school	elem. – high school	residential treatment	university clinic
Sample size	61	311	12	36 couples
Problem	academic, pers, social	unspecified	depression; oppositional	marital relat.
Selection criteria?	no	no	no	no
Demographics	52% male; ave age: 16	53% male; elem. – high school age	male & female age: 10-14	marr. couples; age: most in 30's
<b>Intervention</b>				
# SFBT core conditions	2	5	7	3
Modality	individual	group	supervision	couples group
# sessions	1	8	4	6
Treat. manual?	yes	yes	yes	yes
Monitored?	no	no	no	yes
Therapist experience	counselors; newly trained in SFBT	counselors; newly trained in SFBT	newly trained in SFBT	trainees & recent grads.
<b>Design</b>				
Type	post-test only comparison group	pre/post-test comparison group	post-test only comparison group	pre/post-test comparison group
Randomized?	yes	yes	matched	non-distressed
Comparison group	problem-focused brief therapy	standard counseling groups	standard child care	no treatment
<b>Outcomes/ Results</b>				
Measures used – end of treatment outcome	self-ratings of problem severity, goal attainment, and intensity of feelings	Index of Personality Chara. – sig. between group differences on 3 of 8 scales; Counselor reports – 81% achieved goals	serious incident reports (restraints, police, hosp.); medication use	Dyadic Adjustment Scale – sig. change in tmt group on all 5 scales; posttest scores approached pretest scores of non-distress group
Followup	2 and 6 weeks – no sig. between group differences on any of the measures	none	16 weeks – 65% tmt vs. 15% control reduction in incident rpts; tmt group decreased/ control incr. med use	none