

Practitioner Report

How Brief is Solution Focussed Brief Therapy? A Comparative Study

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Solution Focused Brief Therapy (SFBT) focuses on clients' strengths and expressed goals in an attempt to produce therapeutic change as quickly as possible. This study examined whether clients seen for SFBT were seen for fewer sessions than those seen for cognitive behaviour therapy (CBT) in a clinical psychology service taking adult referrals from primary care. The study was a retrospective one using pseudo-randomization. The results indicated that SFBT clients ($n = 41$) were seen for two sessions on average compared to five for CBT ($n = 119$). This difference was accounted for by a higher proportion of the SFBT group being seen for one session only, which is consistent with the approach. A simple therapist-rated outcome scale showed no significant difference between the two groups. Copyright © 2005 John Wiley & Sons, Ltd.

Solution focused brief therapy (SFBT) has been gaining popularity over the past few years because of its emphasis on fast therapeutic change and respect for the client's perspective, both of which are consistent with current healthcare philosophy. The therapeutic focus is a future orientation specifically based on the client's expressed aims. The process involves the therapist asking questions designed to enable clients to visualize in detail desired outcomes and identify their strengths, resources and times when the problem is not in evidence. At the end of a session, the therapist gives a series of compliments to the client based on what has emerged from the discussion. Tasks may be set, but these are 'no fail', such as asking the client to do more of what is already working, or to observe

what happens in their life that they would wish to continue (for a practical overview of the therapy see George, Iveson, & Ratner, 1999). The therapy is sometimes described as 'atheoretical', but this refers only to the therapist's listening strategy, which is to accept directly what the client is saying rather than seeking to match it to a specific conceptual framework. It is, in fact based on social constructionist and linguistic analyses (see, e.g., de Shazer, 1991, 1994).

The earliest evidence regarding the effectiveness of SFBT came from a case-series evaluation of 275 clients seen at the Brief Family Therapy Centre in Milwaukee, USA, where the approach originated (De Jong & Hopwood, 1996). At the end of therapy, 74% of clients reported subjective improvement on the ten-point scale often used as part of the therapy. At 9 month follow-up, 77% reported that some progress had been made in therapy. Interestingly, these results were not affected by a number of baseline variables including type of problem (which included depression, anxiety and family violence), age (one-third of clients were children), gender and race. 80% of the clients had four

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sessions of therapy or fewer (range 1–13). The average number of sessions for which clients were seen was 2.9, which contrasts with a duration of six to nine sessions in other therapies (Miller, Hubble & Duncan, 1997). In the UK, Macdonald (1994) studied a series of 41 referrals to a brief therapy service in adult psychiatry and found a 70% 'good outcome' rate at one year follow-up. Good outcome was defined as the client (or, if they were unavailable, the general practitioner) rating the presenting problem as solved. Good outcome was linked to a greater number of sessions and setting goals for therapy but not to any other baseline variables, including client inpatient/outpatient status and whether they were discharged or simply lapsed from treatment. Clients were seen for a mean of 3.7 sessions. A recent review by Gingerich (2000) cites five studies described as well controlled suggesting effectiveness of SFBT in areas as diverse as orthopaedic rehabilitation, student depression and recidivism in offenders. 'Well controlled' was defined as meeting at least five of six criteria, which included design quality, focus on a specific disorder, verified adherence to treatment and validated outcome measures. He also describes ten less well controlled studies generally supportive of the approach. In most of these studies the number of sessions was fixed beforehand. An exception was a study by Lambert, Okiishi, Johnson, and Finch (1998), which appears to be the only published study specifically looking at the efficiency of SFBT. They compared 27 patients seen by a solution focussed therapist with 45 patients by a group of 36 therapists in training using an eclectic model, using the same outcome measure, the OQ-45. The mean number of SFBT sessions was 3.1. After two sessions, 36% of the SFBT group had met the criteria for recovery compared with two per cent of the eclectic group, and overall the SFBT group achieved similar outcomes three times faster. Limitations of this study were the vastly different level of therapist experience in the two groups (the solution focussed therapist had 20 years experience, in contrast to the trainees) and the lack of randomization: the eclectic therapy data was taken from an earlier study. The present study aims to address these limitations by using clients from a single pool allocated to different therapies on a quasi-randomized basis.

RESEARCH AIMS

The main purpose of the present study is to compare the number of sessions for which clients

are seen in SFBT with cognitive-behaviour therapy (CBT). This comparison would be limited without some measure of outcome, so a simple, therapist-rated outcome measure was included as a check on this. Attendance rates in the two groups were also compared.

METHOD

Data for the study was extracted retrospectively from the local clinical psychology service's database containing client information routinely collected by therapists. All adults seen by clinical psychologists for a first appointment in a one year period were considered. The referral source was GPs in the local area. Any client episode which identified CBT or SFBT as the sole therapeutic intervention was included in the study and formed the comparison groups, with 119 in the CBT group and 41 in the SFBT group. On reaching the top of the waiting list, clients were allocated to the first therapist who had an appointment slot available, irrespective of problem type or other factors; effectively a form of quasi-randomization. The choice of therapeutic approach was made by the therapist. One of the therapists (the author) used SFBT with all clients, whilst most of the other therapists used CBT, hence the different numbers in the two groups.

A number of demographic and other variables were included. As previous research has suggested that SFBT can be effective over a very wide range of presenting problems, diagnosis was not used as an inclusion criterion. In fact, the whole group had a range of problems fairly typical of a primary care psychology caseload, the most common problems being anxiety and panics (43%), depression (12%), anger (11%), relationship problems and eating disorders. Outcome was measured by the seven-point scale routinely rated by the therapist at the end of therapy. This was not generally completed for defaulters from therapy.

RESULTS

Baseline comparisons revealed that there were significant differences between groups in gender, deprivation category, age, waiting time before being seen for therapy, therapist experience (years since qualifying) and therapist rated severity, using the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1994)—see Table 1. However, multiple regression analysis

Table 1. Baseline comparisons

	SFBT	CBT	Significance
Male/female (%)	22/78	50/50	$p < 0.01$
DEPCAT	3.5 (SD = 1.1)	3.9 (0.8)	$p < 0.05$
Age	34 (12)	38 (13)	($p < 0.1$)
Days waiting	55 (26)	74 (43)	$p < 0.01$
T experience	17 yr (2.2)	10 (6.7)	$p < 0.001$
GAF	55 (9.9)	59 (10.4)	($p < 0.1$)

Table 2. Results: number of sessions

	SFBT	CBT	Sig.
Sessions attended	Median = 2 (25% = 1, 75% = 4)	5 (2, 9)	$p = 0.003$
Did not attend	2 (1, 3)	2 (1, 4)	n.s.
Total sessions	4 (3, 8)	8 (5, 11)	$p = 0.002$

revealed that there was no linear relationship between any of these baseline variables and the outcome measures.

Non-parametric tests were also used to analyse sessions seen, as this has a skewed distribution (see Figure 1). There was a statistically significant difference between the two groups in number of sessions seen, with SFBT clients being seen on average for two sessions and CBT for five (see Table 2). Type of therapy did not affect the attendance rate. When time allocated to missed appointments was included, twice as much therapist time was allocated to CBT clients as to SFBT. The multiple regression revealed that the group difference in sessions was accounted for by a greater proportion of clients in the SFBT group being seen for one session only—41% as opposed to 18% in the CBT group (see Figure 1). The great majority of one session attenders in both groups were classified by the therapist as drop-outs: in no instance was the therapy classified as being completed in one session (which can happen with SFBT). The seven-point outcome scale completed by the therapist at discharge (1 = most successful) showed no difference in the two groups (SFBT mean = 2.2, CBT mean = 2.3, n.s.).

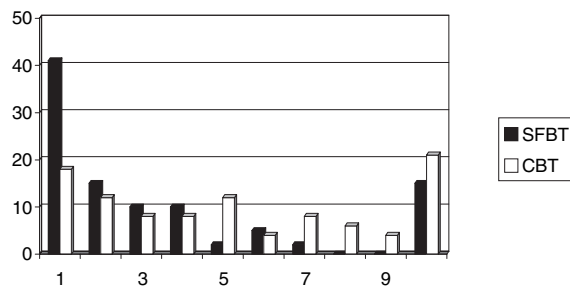


Figure 1. Number of sessions seen (%)

DISCUSSION

In this study, SFBT was, indeed, briefer than CBT for primary care psychology clients. That the difference is accounted for by single session attenders is consistent with the brief therapy approach. This is designed so that each session is self-contained, on the assumption that any given session may be the last. Therapy therefore starts immediately in SFBT. With CBT, therapy follows one or more assessment sessions and a contract is usually made for a specific number of meetings, e.g. 5–10, with a review. Although many of the single session clients were drop-outs, previous follow-up research has suggested that the outcome for drop-outs is as good as for therapy completers in both SFBT and CBT (Macdonald, 1994; Simons, Levine, Lustman, & Murphy, 1984). This implies that many clients drop out of therapy because they are happy with their progress but simply fail to contact the therapist. It should be noted that there was no specific attempt to limit the length of therapy in the SFBT group and, in fact, the client with the longest therapy—47 sessions—was in the SFBT group.

This was a small study with inevitable limitations. First, all except one of the SFBT clients were seen by one psychologist (the author) whilst the CBT group were seen by several other psychologists. This raises the possibility that therapist may be a confounding variable, but therapist experience, which can affect dropout rates and possibly therapeutic outcome (Roth & Fonagy, 1996, pp. 343–346), showed no relationship to outcome in this study. Other studies have tried to control this variable by having the same therapist carry out the experimental and control therapies. This also introduces a possible source of a bias as the therapists are generally enthusiasts for the experimental approach and are carrying out a control therapy

that they are not expecting to be particularly effective: therapist optimism has been shown to be an important non-specific factor in treatment (Benson & Friedman, 1996).

A second limitation is that the groups were not systematically randomized. Clients were simply taken from the top of the waiting list when a psychologist had a space available. We are not aware that this produced a source of bias as referral information did not influence which therapy was selected. Third, the outcome measure is obviously basic and therapist based. The main aim of this study was to look at therapist and client time input, and the outcome data was simply included to check that any reduction in time input was not at the expense of effectiveness.

The results have potential significance for the resource-limited NHS and, in fact, SFBT is being increasingly used by therapists. Despite the limitations of this study, it is suggested that the results are sufficient to justify further research looking at the cost-effectiveness of SFBT with clients referred from primary care.

ACKNOWLEDGEMENTS

Thanks to Cathal McAuliffe, Patricia Conway, Suzi McAlpine, Joanne Little and Margaret McKay for assistance, and to Rob Elton and Kate Howie for statistical advice. This research was supported by a research grant from Forth Valley Primary Care NHS Trust.

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