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# The Global Outcomes of Solution-Focused Brief Therapy: A Revision

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## ABSTRACT

Solution-focused Brief Therapy (SFBT) has generated outcome research worldwide and in a variety of intervention contexts. A systematic literature search yielded 251 published outcome studies on SFBT. SFBT was found superior to control groups or at post-test in almost nine out of every ten studies. Taking only 91 randomized controlled trials (RCTs) into account, SFBT was still found superior in seven out of every ten. Results varied slightly according to intervention type and format, manualization, and components of SFBT. They also varied more according to type of comparator and use of diagnostic criteria. These results widen the evidence base for SFBT.

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## KEYWORDS

Solution-focused Brief Therapy; outcome research; evidence-based practice

## Introduction

Solution-focused Brief Therapy (SFBT) is a therapeutic approach developed by Steve de Shazer, Insoo Kim Berg and their associates at the Brief Family Therapy Center in Milwaukee, Wisconsin in the eighties. SFBT developed from the tradition of strategic brief family therapy (Weakland et al., 1982) as a way to complement its intervention on interactional problem patterns (De Shazer et al., 1986), but evolved into a radical approach that changed the therapy focus from problems to what was called “solutions”: exceptions to the problems, strengths, improvements, and goals (de Shazer, 1994; de Shazer et al., 2007).

At the level of practice, solution-focused therapists co-construct solutions in dialogue with their clients by focusing on their desired futures and those occasions when parts of those futures are already happening, capitalizing on clients’ strengths and past successes instead of analyzing problems and their causes. SFBT is therefore not a problem-solving procedure, but a process of solution construction. Solution-focused practices are based on the trust in the capabilities and strengths of people, the rejection of the “illness ideology” (Maddux, 2008) and the deconstruction of diagnostic labels (de Shazer & Berg, 1992). SFBT is not construed as specific therapy for specific “disorders”,

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but as a general procedure that can help all kind of clients achieve their own goals, working from a position of curiosity and humility.

SFBT takes a constructivist and non-expert approach to wellbeing that leads to a constant effort to adjust each intervention to the individual persons and families, to respect their worldviews and use their values and beliefs as resources for change. This collaborative stance makes SFBT especially suited to work within different cultural contexts, and to intervene with cultural minorities and specific communities (Kim, 2013; Ouer, 2016). Furthermore, SFBT developed as a brief intervention to construct workable solutions in difficult contexts. The solution-focused emphasis on simplicity and the use brief interventions also increases its applicability with under-privileged populations.

Over the last decades, SFBT has expanded well beyond the geographical context in which it developed. In a bibliometric study on SFBT research, Beyebach et al. (2021) found 365 outcome studies on SFBT, carried out in 33 countries from all continents, on all kinds of samples and on a variety of intervention formats: psychotherapy, coaching, school and college counseling, child protection, community interventions and organizational interventions. They concluded that SFBT has been applied and researched globally, with a balanced distribution of research between western and industrialized *versus* non-western, not industrialized countries. However, the results of these outcome studies were not analyzed, so the question of to what extent the tested SFBT interventions had been effective was not addressed.

The effectiveness SFBT has been supported by a number of systematic reviews (Bond et al., 2013; Corcoran & Pillai, 2009; Gingerich & Eisengart, 2000; Gingerich & Peterson, 2013; Liu et al., 2015; Suitt et al., 2016; Woods, 2015) and meta-analyses (Carr et al., 2017; Franklin et al., 2020; Gong & Hsu, 2015, 2016; Hsu et al., 2021; Huoliang & Weisu, 2015; Kim, 2008; Kim et al., 2015, 2017; Park, 2014; Schmit et al., 2016; Stams et al., 2006; Zhang et al., 2018), but the sample of outcomes studies on which each of these reviews and meta-analyses are based is typically small, ranging from six (Suitt et al., 2016) to 50 (Franklin et al., 2020), with an average of 24 studies for meta-analyses and 21 for systematic revisions. This is in part due to the stringent inclusion requirements of meta-analytic procedures, that leave out many available studies, but also to the fact that meta-analyses address specific research questions. Therefore most of these analyses of SFBT research have restricted their scope to a limited number of countries (Gong & Hsu, 2016; Kim et al., 2015), presenting problems (Hsu et al., 2021; Schmit et al., 2016), settings (Zhang et al., 2018), or intervention formats (Carr et al., 2017; Kim et al., 2017). What is missing is a global, comprehensive perspective on the effectiveness of SFBT practices that takes all existing outcome research into account. Therefore, the purposes of the current study were:

1. To examine the features of the outcome research papers on SFBT published worldwide over the last thirty years.
2. To analyze the effectiveness of SFBT interventions globally.

## **Method**

### ***Search methods***

A systematic literature search was performed on nine databases (Web of Science Core Collection (WOSCC), Medline, Scopus, PsycINFO, ERIC, Embase, PubMed, ASSIA y SciELO) plus the research data bases of the Solution Focused Brief Therapy Association (SFBTA) ([sfbta.org/current-research](http://sfbta.org/current-research)), and of the European Brief Therapy Association (EBTA) (McDonald, 2017). The same inclusion and exclusion criteria were used at all stages of the selection process. Inclusion criteria were: (a) original research articles, (b) published in scientific journals, (c) on the outcome (effectiveness or efficacy) of psychosocial interventions in which (d) at least one component was solution-focused. We excluded: (a) non-original research papers, (b) research papers that did not focus on interventions, (c) research papers that focused only on the process of a SFI (not on its outcome). Papers with non-accessible content were also excluded.

2251 records were initially identified. After removal of duplicates, 1144 remained. A first reading of the titles and abstracts eliminated another 528 records. Afterwards, the whole data base was reviewed, selecting 365 records for the bibliometric analysis. The few disagreements between the authors were discussed and solved by consensus.

### ***Coding process***

The 365 extracted records were coded on a number of variables. To this end, the variables were operationally defined, and these definitions were tested on a small number of studies. Once acceptable interrater reliability had been established, half of the records were coded by the first author and the other half by the second one. Twenty-five percent of the records were independently coded by both authors, so that the reliability of these codifications could be established. Those papers for which data on more than three of the coded variables were missing were excluded from the sample. All papers for which the “outcome” variable could not be coded were also excluded. After records with missing data had been removed, the final sample included 251 studies, conducted on a total sample of 27818 subjects.

### ***Variables***

The following variables were coded, all with mutually exclusive categories:

### ***Intervention type***

The SFBT interventions in each study were classified as psychotherapy, coaching, school/college counseling, child protection, community interventions, or organizational intervention. Inter-rater reliability for this variable was  $k = .93$

### ***Intervention format***

The SFBT interventions tested in each study were classified as individual, group, family, or couple interventions. Inter-rater reliability for this variable was  $k = .97$ .

### ***Manualization***

The SFBT interventions tested in each study were considered manualized if the paper stated explicitly that a treatment manual had been used or provided a detailed a priori description of the procedure that had to be followed in the intervention. They were classified as non-manualized if no claims that a manual had been used were made or if authors provided only a description of how the intervention had been carried out, but not an *a priori* description of how it should be undertaken. Inter-rater reliability for this variable was  $k = .98$ .

### ***Diagnosis***

The studies were coded according whether the subjects in the sample had been recruited on the basis of a diagnosis according to DSM or CIE criteria, or according to some standardized diagnostic instrument (for instance, Beck's BDI). Inter-rater reliability for this variable was  $k = .93$ .

### ***Weight of the solution-focused component***

SFBT was coded as the "only component" of the tested intervention when only SFBT principles and techniques were used, as the "majoritarian component" when a basically SF intervention with some non-SFBT additions was tested, as a "50% component" intervention if SFBT and some other approach were integrated with similar weights, as a "minority component" used with a main ingredient that was not SFBT, or as the study of some isolated SFBT techniques (for instance, the use miracle question or the use of scaling questions). Inter-rater reliability for this variable was  $k = .98$

### ***Study design***

The SFBT interventions tested were classified as randomized trial when at least two groups were compared, with random assignment of subjects to groups; as quasi-experimental non-randomized trials when at least

two groups were compared, with no random assignment of subjects to groups; and as naturalistic studies (pre-post comparison) when only one group was studied. The other two categories in this variable were single case designs and qualitative designs. Inter-rater reliability for this variable was  $k = .95$

### ***Type of comparison group***

Studies with control group (randomized trials and quasi-experimental non randomized trials) were classified, according to the type of control, as no treatment, waiting list, placebo, “treatment as usual” (TAU) or alternative treatment. Studies with a single case or a single group were categorized as with no control group. Inter-rater reliability for this variable was  $k=0.98$

### ***Dependent variables***

Were coded as “psychological variables” if questionnaires were used to measure psychological constructs (for instance measures of affect, cognitive complexity or anxiety); as “behavioral outcomes” when certain objective outcomes were reported (for instance, absenteeism; days on sick leave); “behavioral checklist” when the informant reported certain observable behaviors (for instance, ratings by parents or teacher of disruptive children behavior). Dependent variables could also be physiological variables (for instance, skin conductance), therapist’s ratings of progress or a combination of several of these categories. Inter-rater reliability for this variable was  $k = .93$

### ***Outcome***

For studies with two or more groups (randomized and quasi-experimental trials) the outcome of the SFBT intervention was coded as superior, inferior, mixed or with no differences. The outcome of SFBT was categorized as superior if SFBT achieved significantly superior results in at least one dependent variable, without being significantly inferior in any other. The outcome of SFBT was coded as inferior if SFBT achieved significantly inferior results in at least in one dependent variable, without being significantly superior in any other. The outcome was coded as mixed if SFBT achieved significantly superior results in at least one dependent variable, but also significantly inferior results in at least one. The outcome received a “no difference” code if there were no significant differences between the SFBT intervention and the control in any of the dependent variables. Inter-rater reliability for this variable was  $k = .95$ .

For the final sample, the number of sessions of the SFBT conditions was extracted. The session average was taken; if it was not reported, the

maximum of sessions offered was used. There were 155 studies from which neither the average nor a maximum of sessions could be extracted. For the 96 studies in which this was possible, the range of sessions was 1-24, with an average of 5.66 and a SD of 3.59.

The number of follow-ups and their time span since termination were also extracted. Follow-ups were reported in 101 out of the 251 studies. They ranged from 1 to 60 months, with an average of 5.98 months and a SD of 14.09.

All data obtained were stored and descriptively analyzed with Microsoft Excel. In addition, chi-square analysis and Z-test were performed with the IBM SPSS Statistics 28 to test possible differences.

## Results

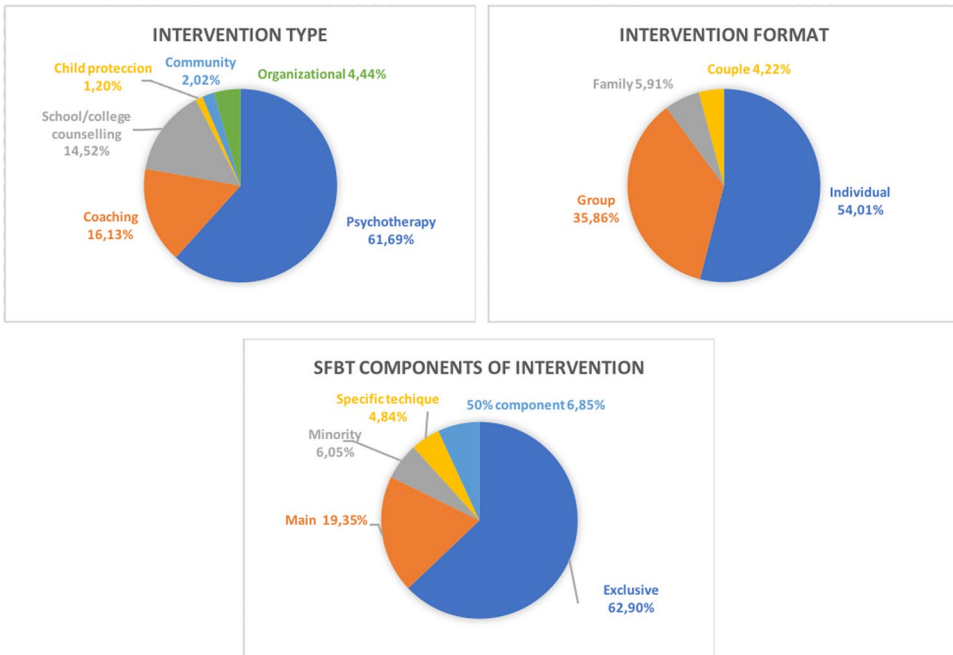
### *Features of the outcome studies*

As far as the intervention type is concerned (Figure 1), a majority of the SFBT interventions in our sample of outcome studies were classified as psychotherapy, followed by coaching and school counseling. Less frequent were publications of outcome research on organizational SFBT, community SFBT interventions, or SF child protection. The proportion of studies on SFBT categorized as “psychotherapy” was significantly higher in those studies undertaken on diagnosed subjects (92.5%) than in studies undertaken on non-diagnosed subjects (49.7%) ( $Z = 4.9$ ;  $p < .0001$ ). As to the format of the interventions, the majority of the tested SFBTs were individual interventions, followed by group interventions, and not many studies were conducted on interventions with families or with couples (Figure 1).

In the majority of the retrieved studies, SFBT was either the exclusive component of the tested intervention or the main component. Only in a small proportion of the analyzed studies the solution-focused component was one of two elements of the intervention, or a minority component. A specific SFBT technique was tested in less than 5% of the studies. (Figure 1).

The tested SFBT interventions were manualized in 33.3% of the studies. Only 20.3% of the studies used formal diagnosis in the sample inclusion criteria.

As far as the scientific design of the studies in our sample is concerned (Figure 2), 36.3% ( $n = 91$ ) of the studies were randomized trials, and 26.3% ( $n = 66$ ) were quasi-experimental studies with non-randomized comparison of two groups. Taken together, 157 studies (62.5% of our sample of extracted studies) involved the comparison of two groups. Naturalistic (one group pre-post design), single case and qualitative studies were the least used designs.



**Figure 1.** Distribution of SFBT outcome studies according to intervention type, intervention format, and component of the interventions.

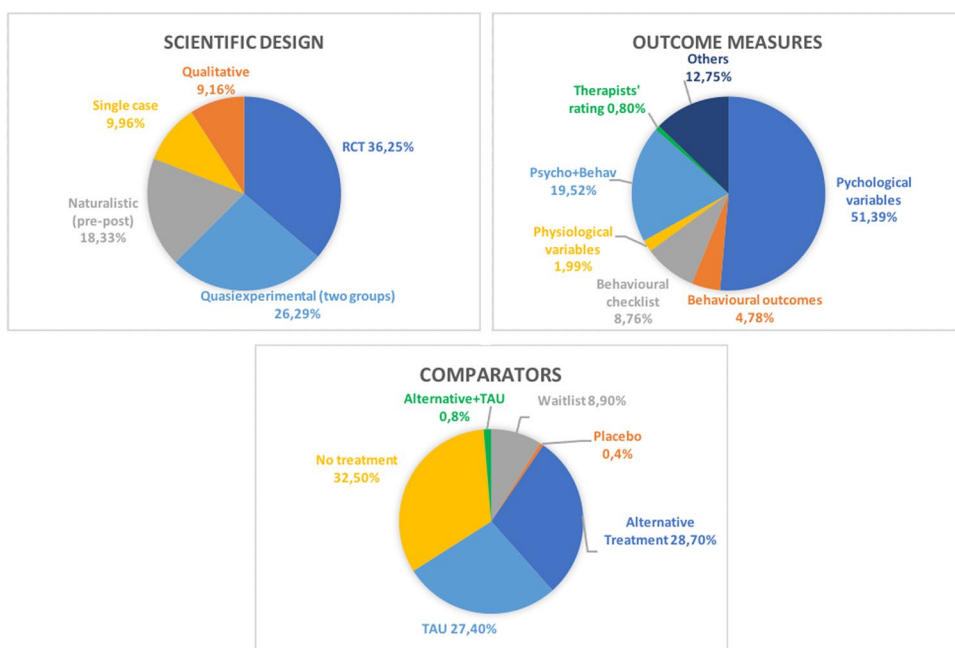
For studies that compared at least two groups, “waitlist” or “no treatment” were the comparators in 41.4% of the studies, placebo was used in only one study, TAU was applied in the control group in 27.40% of the studies, and alternative treatments were used in 28.7%.

As can be seen in [Figure 2](#), the dependent variables most often measured in our sample of studies were psychological variables measured with questionnaires (51,4%), followed by the combination of psychological variables and behavioral outcomes (19,5%). In 8.8% of the studies only behavior checklists were used, and 4.8% measured only behavioral outcomes (absenteeism, recidivism...). Therapist’s progress ratings were seldom used as dependent variables and physiological variables, alone or in combination with other variables, were used in very few studies.

### ***Effectiveness of SFBT***

Taking all 251 SFBT outcome research studies into account, a vast majority found that SFBT had positive outcomes (86.3%). SFBT achieved inferior results (worse outcome than the comparison group, or deterioration in pre-post, single case studies or qualitative studies) in 2.8% of the studies. Results were mixed in 2.4% of the studies and no differences were found in 8.5% of them.





**Figure 2.** Distribution of SFBT outcome studies according to their scientific design, their outcome studies, and their comparison groups.

**Table 1.** Outcomes of SFBT interventions according to study design.

Study Design		SBFT superior	SFBT inferior	No differences	Mixed results	Total N (%)
		N (%)	N (%)	N (%)	N (%)	
<b>Study Design</b>	RCT	66 (72.5%)	7 (7.7%)	12 (13.2%)	6 (6.6%)	91 (100%)
	Quasiexperimental (two groups)	58 (89.2%)	0 (0.0%)	7 (10.8%)	0 (0.0%)	65 (100%)
	Quasiexperimental (pre-post)	42 (95.5%)	0 (0.0%)	2 (4.5%)	0 (0.0%)	44 (100%)
	Single Case	25 (100%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	25 (100%)
	Qualitative	23 (100%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	23 (100%)
<b>Total</b>		214 (86.3%)	7 (2.8%)	21 (8.5%)	6 (2.4%)	248 (100%)

Analyzing effectiveness according to scientific design, significant differences in the outcome percentages emerged ( $X^2= 33.629$ ;  $p < .001$ ), as can be seen in Table 1. SFBT was less often found superior in randomized trials than in quasi-experimental studies ( $Z=2.5$ ;  $p = .01$ ) and in naturalistic pre-post comparisons ( $Z=3.1$ ;  $p = .001$ ). On the other hand, SFBT was found to be inferior to the comparison group in 7.7% of the RCTs, but not in any of the quasi-experimental studies.

The type of comparison group used in the studies also made a difference. Taking only RCTs and quasi-experimental two-groups designs into account, SFBT was found superior in 94.1% of the comparisons with no-treatment groups, in 100% of the comparisons with waitlist controls or with placebo controls, in 88.4% of the comparisons with TAU and in 46.7% of the comparisons with alternative treatments. Restricting the

**Table 2.** Outcomes of SFBT interventions in RCT according to comparison group.

		SFBT superior N (%)	SFBT inferior N (%)	No differences N (%)	Mixed results N (%)	Total N (%)
<b>Comparator</b>	No treatment	22 (95.7%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	23 (100%)
	Waitlist	9 (100%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	9 (100%)
	Placebo	1 (100%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100%)
	TAU	20 (83.3%)	0 (0.0%)	4 (16.7%)	0 (0.0%)	24 (100%)
	Alternative treatment	12 (37.5%)	7 (21.9%)	7 (21.9%)	6 (18.8%)	32 (100%)
	Alternative + TAU	1 (1.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100%)
<b>Total</b>		65 (72.2%)	7 (7.8%)	12 (13.3%)	6 (6.7%)	90 (100%)

analysis to the 91 RCTs (Table 2), we found that the type of control group still had a significant effect on the results of the studies ( $X^2 = 37.049$ ;  $p = .001$ ). Results follow a clear pattern: at least 90% of the studies in which the SFBT group was compared to no-treatment, waitlist of placebo showed significant superiority for the SFBT group; when the comparator was TAU, SFBT was found to be superior in 83.3% of the cases; and when it was an alternative treatment, SFBT was superior in 37.5% of the studies. The percentage of inferior results for the SFBT condition shows the opposite picture: 0% in comparison with no-treatment, waitlist, placebo, or TAU, and 21.9% in comparison to alternative treatments.

The type of intervention tested made no major difference in terms of the effectiveness of SFBT in the 251 analyzed studies, given that globally speaking the distribution of outcomes by type of intervention was random ( $X^2 = 12.557$ ;  $p = .636$ ). However, SFBT was significantly more often found effective in school counseling studies (in 97.3% of these studies) than in psychotherapy studies (80.8% of these studies), a significant difference ( $Z = 2.4$ ,  $p = .016$ ). This finding is not caused by an over-representation of RCTs in psychotherapy, given that there was no significant difference in the proportion of RCTs in psychotherapy vs. counseling outcome studies ( $Z = 1.3$ ;  $p = .1903$ ). Restricting the analysis to the 91 RCT studies, a similar trend was detected (91.7% of SFBT superiority in school or college counseling studies; 75% in coaching studies, and 69.6% in psychotherapy studies), but the differences were not significant anymore. There were no significant differences in SFBT superiority between intervention formats, except for group interventions, for which there were significantly more studies finding SFBT superior (92.8%) than in individual interventions (81.1%) ( $Z = 2.4$ ;  $p > .017$ ). In family and couple interventions, SFBT was found superior in 78.6% and in 100% of the studies respectively.

The weight of the SF component within the studied SFBT intervention had no impact on the effectiveness of SFBT ( $X^2 = 17.261$ ;  $p = .140$ ). The only significant difference was the difference between studies where SFBT was a majoritarian component (88.2%) and studies where a single SF technique was tested (50%).

**Table 3.** Outcomes of SFBT interventions according to manualization and diagnosis.

		SBFT superior N (%)	SFBT inferior N (%)	No differences N (%)	Mixed results N (%)	Total N (%)
<b>Manualization</b>	Yes	60 (88.2%)	0 (0.0%)	8 (11.8%)	0 (0.0%)	68 (100%)
	NO	114 (85.1%)	7 (5.2%)	7 (5.2%)	6 (4.5%)	134 (100%)
<b>Total</b>		174 (86.1%)	7 (3.5%)	15 (7.4%)	6 (3.0%)	202 (100%)
<b>Diagnosis</b>	Yes	24 (60%)	5 (12.5%)	5 (12.5%)	6 (15.0%)	40 (100%)
	NO	147 (94.8%)	1 (0.6%)	7 (4.5%)	0 (0.0%)	195 (100%)
<b>Total</b>		171 (87.7%)	6 (3.1%)	12 (6.2%)	6 (3.1%)	202 (100%)

As can be seen in Table 3, the manualization of the intervention had an impact on the outcome of the SFBT intervention in the total sample of 251 studies ( $X^2 = 9.248$ ;  $p = .026$ ). Although the proportion of superior results for SFBT was not significantly higher in manualized interventions than in non-manualized intervention, manualized SFBT was significantly less likely to have inferior or mixed outcomes than non-manualized SFBT ( $Z=7.3$ ;  $p < .0001$  and  $Z=6.6$ ;  $p < .0001$ , respectively); “no difference” results were more likely in studies on manualized SFBT than on non-manualized SFBT ( $Z=5.5$ ;  $p < .0001$ ). When only the 91 RCT studies were taken into account, the distribution was still significant overall ( $X^2 = 11.154$ ;  $p = .011$ ) with the same pattern: no statistically significant difference in the percentage of superior SFBT results, and differences for inferior results ( $Z = 2.3$ ,  $p=.023$ ), no differences ( $Z=6$ ,  $p=.0001$ ), and mixed results ( $Z=2.1$ ,  $p=.0373$ ).

The use of diagnostic criteria to select the samples had an impact on the outcome of the SFBT intervention ( $X^2= 45.466$ ;  $p < .001$ ) (Table 3), with a higher percentage of studies that found superior outcomes for SFBT in studies conducted on non-diagnosed subjects than in studies on diagnosed subjects ( $Z=6$ ;  $p = .0001$ ). The impact of diagnosis on the outcomes of the intervention was still significant when only the 91 randomized controlled trials were taken into account ( $X^2= 24.669$ ;  $p < .001$ ), with interventions on non-diagnosed samples being more often superior to interventions on diagnosed ones.

## Discussion

### *Features of the outcome studies in our sample*

The first purpose of our study was to describe the features of the existing SFBT outcome research. As far as the intervention type is concerned, it is not surprising that over one half of the SFBT interventions in our sample of studies were classified as psychotherapy, given that SFBT has its origin in the therapy field. The expansion to non-clinical intervention contexts is shown by the fact that coaching and school/college counseling together account for

another third of the studies, with less SFBT outcome research on organizations, community interventions or child protection. As to their format, the tested SFBTs were individual interventions in half of the studies and group interventions in one third, with family and couple interventions accounting together for less than 10% of the studies. This shows to what extent SFBT has expanded beyond the family therapy field. However, given the history of SFBT and its widespread use by family therapists (Bradley et al., 2010), we find the relative scarcity of research on SF family therapy surprising.

The SFBT interventions were manualized in only one-third of the retrieved outcome studies. We see this as a shortcoming of the body of research we have analyzed: given that SFBT is a very flexible approach, using a SFBT manual would ensure that what is being tested is really SFBT and that non-SFBT elements are not included in the treatment. This would be especially relevant for those studies (eight out of every ten) in which SFBT was presented as either the exclusive or the main component of the tested intervention.

As far as the scientific design of the studies in our sample is concerned, 91 studies were randomized trials and 66 were quasi-experimental studies with non-randomized trials of two groups. Taken together, 62.5% of our sample of extracted studies involved the comparison of two groups. We find the proportion of RCTs relatively high, taking into account that a large proportion of the extracted studies were conducted in contexts, like social work or schools, in which RCTs are not necessarily the “golden standard”, and also the fact that in many of these contexts solution-focused practices have been introduced only recently.

Among the studies that compared at least two groups, “waitlist” or “no treatment” were the comparison groups in four out of every ten studies, followed by alternative treatments and TAU, which were each used in one quarter of the cases. We see the over-reliance on weak comparators (waitlist or no treatment) as another shortcoming of the body of outcome research on SFBT.

We find it positive that therapist’s progress ratings were almost never used as the sole dependent variable in our sample of research papers. The most frequent dependent variables were psychological variables assessed by questionnaire(s), used in more than half of the extracted papers. In around one-fourth of the studies behavioral outcomes were also assessed, alone or in combination with questionnaires. We hope that in the future more studies will also measure physiological variables.

Finally, two other weakness of the outcome research on SFBT become apparent in our data. On the one hand, in more than half of the studies, the number of sessions of the tested interventions is not clearly reported. On the other hand, follow-ups were conducted in less than half of the studies.

### ***Effectiveness of the SFBT interventions***

In spite of the aforementioned shortcomings of the body of SFBT outcome research, our data provide a clear answer to our second research question. Our results show that in the vast majority of the SFBT outcome studies published to date, SFBT demonstrates to be effective, with more than four out of every five studies showing a positive effect of SFBT, and less than 3% showing inferior results than controls or deterioration in relation to pretest. These results are influenced by the type of scientific design used in the outcome studies: SFBT fares better in quasi-experimental studies, where nine out of every ten studies show positive effects for SFBT, than in randomized controlled trials, where SFBT is found to be superior to the control group in seven out of every ten studies. In addition, no quasi-experimental studies found deterioration or inferiority of the tested SFBT, whereas a 7.7% of the randomized controlled trials found evidence of this.

When only RCTs are examined, a clear pattern emerges: RCT that use alternative treatments as controls are significantly less likely to produce superior outcomes for SFBT than those that compare SFBT with TAU or with no treatment, waitlist, or placebo controls. In a complementary fashion, one out of every five RCTs that compare SFBT to alternative treatment finds SFBT to be inferior to the comparison group, with no inferior results in studies that used other comparators. This pattern of results can be explained by the relative strength of different control conditions, but also by the influence of possible allegiance effects. Studies with TAU as control groups are more likely carried out by teams who believe that SFBT can improve the interventions that are usually delivered (and are therefore allegiant to SFBT), whereas comparisons of SFBT with alternative treatments are more likely to be carried out by teams whose allegiance lies with the non-SFBT treatment, as can be assumed to have happened in some of the best designed outcome studies to date (Boyer et al., 2016; Creswell et al., 2017; Lindfors et al., 2015).

In any case, we find it remarkable that even with the most stringent design, the comparison of SFBT to alternative treatments, four out of every ten studies find SFBT superior to the comparator, another four get mixed results or find no differences, and only in two out of every ten studies SFBT gets worse results than the alternative treatment. In our view, these data make a strong case for the effectiveness of SFBT, in line with the positive results of the meta-analyses that have been published so far. It is also interesting to mention that the results were obtained with relatively brief interventions, with an average number of sessions under six.

The likelihood of finding positive effects for SFBT seems not to be influenced by whether the SF component is more or less present in the tested intervention. The only exceptions are studies on the effectiveness

of single solution-focused techniques, where half of the studies fail to support the superiority of the tested intervention. This is coherent with the idea that SFBT is more than a set of techniques and that the global pattern of conversation is more important than the use of any separate part of it. On the other side, the fact that interventions in which the SF component is mixed or integrated with other techniques and approaches are as likely to produce superior outcomes as interventions where SFBT is the only component provides indirect support to the idea that SFBT can be integrated with other techniques and approaches without weakening its impact. Direct comparison between “pure SFBT” and “integrative SFBT” approaches would shed more light on this question, but no such comparisons have been carried out so far.

A related question is that of manualization, for which results are less clear. Studies on manualized SFBT are not more likely to find positive results but are less likely to find negative ones than those in which SFBT is not manualized. This provides some indirect evidence for the value of manualization of SFBT, as promoted by the American Solution Focused Brief Therapy Association and the European Brief Therapy Association.

We find it interesting that the percentage of studies in which SFBT yields superior results than the comparison groups is significantly higher in school settings than in psychotherapy settings. These findings support the claims on the potential of SFBT interventions in schools (Kelly et al., 2008; Metcalf, 1995) and align with previous reviews and meta-analyses which reported positive effects for SFBT as a school-based intervention (Franklin et al., 2020; Gong & Hsu, 2016; Kim & Franklin, 2009; Park, 2014). On the other side, the fact that SFBT seems less likely to produce superior outcomes in studies on psychotherapy might point to a relative weakness of SFBT in the clinical field. This interpretation is also supported by comparing research on samples of clients with and without a formal diagnosis, given that in studies on samples with a formal diagnosis the effectiveness of SFBT seems to shrink. This is the case for the whole sample of 251 studies, but becomes more evident if the analysis is restricted to the 91 RCTs: here SFBT is found to be superior in 87% of the studies on non-diagnosed samples, but only in 37,5% of the studies on diagnosed samples.

### ***Limitations and future research***

Among the strengths of our study, we would like to emphasize that we extracted data from the nine most relevant databases and complemented it with a manual search in the SFBTA list. This rigorous process led to the retrieval of 365 research studies from around the world, undertaken on a variety of samples in a great diversity of intervention contexts. These studies were categorized reliably according to a variety of dimensions. The

251 studies included in our final sample were conducted on almost thirty-thousand subjects.

Alongside these strengths, there are also some weaknesses of our study. First, we had no access to “non-western” databases, and a number of publications in Chinese and in Parsi, among others, could be retrieved but not translated; therefore, our sample of studies may be misrepresenting “non-western” research. The high proportion of studies with missing information on relevant variables led to another reduction of the sample, so that only 251 papers from the initial database could be used for our analyses. The conclusions on the analyzed papers cannot be generalized to those studies that had to be excluded.

Second, our analysis of SFBT outcomes was categorical. Our categories of “superior results”, “inferior results”, “mixed results” or “no differences” are very broad, and presumably lump together studies with different effects sizes. Third, although we analyzed how the results of SFBT vary according to variables like the type of intervention tested, the study design, or the type of comparison group used, statistical moderation of the SFBT outcomes by these variables could not be analyzed. Finally, the nature of this review prevented us from calculating the risk of bias of the extracted papers. Meta-analytic studies on selected parts of our sample of studies could address these issues and confirm or disconfirm the trends that we have detected in our review.

### ***Implications for research and practice***

Our results have some important implications. The fact that the great majority of outcome studies on SFBT have so far supported its effectiveness should encourage further outcome research on solution-focused practices, especially in contexts where research is still scarce, like organizational, community and child protection interventions. Our data suggest that researching SFBT in new practice settings and comparing it with TAU is ethically safe, given that in the vast majority of the analyzed studies the SFBT condition produced superior results to TAU and that no studies found inferior results for the SFBT condition. In our view, the cooperative and strengths-focused nature of solution-focused practices makes them unlikely to produce negative effects and offers the promise of smoothing intervention processes and strengthening the therapeutic alliance. According to our data, using a manualized version of the SFBT intervention would reduce the risk of unexpected negative results even more.

At the practice level, the data that SFBT is less often found effective or superior to the controls in studies undertaken in psychotherapy and on diagnosed samples in comparison to those done in other intervention contexts and on non-diagnosed samples is intriguing. It could be taken to



suggest that SFBT interventions are less effective in less clinical contexts and with more distressed populations. However, we think that this interpretation is not sufficiently supported. On the one hand, SFBT was still found effective in six out of every ten studies on diagnosed samples, and in eight out of ten in psychotherapy studies. On the other hand, a sample with diagnosis is not necessarily more distressed than a sample without it.

We found no evidence of any relative advantage or disadvantage of using “pure SFBT” vs. more integrative solution-focused approaches. The possibility of a weaker effect of SFBT with more distressed populations, if confirmed, might point to the need to go beyond SFBT interventions in more severe cases. This possibility needs to be addressed by future research.

## Conclusions

Our review of 251 outcome research papers on SFBT interventions suggest that SFBT is demonstrating effectiveness transculturally, for a variety of practices (psychotherapy, coaching, school counseling, etc.) and intervention formats (individual, group, family/couples). SFBT is typically found to achieve superior results than the controls; this finding is very clear for the comparison with no treatment, waiting list, or TAU, and holds even when SFBT is compared with alternative treatments.

SFBT is more often found effective in studies on SFBT delivered in group than in individual format, and in school and college counseling more than in psychotherapy. Although there are no direct comparisons between pure SFBT interventions and those that integrate SFBT with other ingredients, data suggest that both options tend to be effective. Manualization may contribute to diminish negative results but does not make SFBT more likely to produce superior results. Taken together, our data widen the evidence base for SFBT.

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