Journal of Systemic Therapies, Vol. 19, No. 1, 2000

OUTCOME OF SOLUTION-FOCUSED THERAPY AT A UNIVERSITY FAMILY THERAPY CENTER

M. BEYEBACH, M. S. RODRÍGUEZ SÁNCHEZ, J. ARRIBAS DE MIGUEL, M. HERRERO DE VEGA, C. HERNÁNDEZ, and A. RODRÍGUEZ MOREJÓN
Master Universitario de Formación de Terapeutas Sistémicos, Facultad de Psicología, Universidad Pontificia de Salamanca

This article reports results from a study of solution-focused brief therapy (N = 83) conducted at the Universidad Pontificia de Salamanca (Spain). Outcome at follow-up was similar to that already reported in the literature: 82% of the clients stated that their problems were solved during therapy. On average, client scores on the scaling question increased 3 points (4.2 in the first to 7.2 in the last session), with 3 out of every 4 clients finishing at 7 or more on the scale. Mean number of sessions was 4.7 for the total sample (5.6 excluding dropouts), with almost 70% of the cases taking five or less interviews. Positive outcome at termination (but not at follow-up) was more likely for cases with "personal" complaints than for those with "relational" problems. A trend of favoring expert over trainee therapists in dropout rates was observed but did not reach statistical significance. Outcome at termination proved long lasting, correlating highly with outcome as measured at follow-up. Shortcomings of the study and possible implications of the data are discussed.

Although solution-focused brief therapy (SFBT) has grown in popularity, there is little empirical evidence of its purported effectiveness (Miller, Hubble, & Duncan, 1997). Although a number of controlled outcome studies have appeared in the last two to three years (Gingerich & Eisengart, 1999), most of them have not been carried out in truly clinical settings.

This study sought to provide some more empirical data on solution-focused therapy in an outpatient setting by investigating (1) the general efficacy of SFBT, and (2) the durability of the results of an approach billed as "short-term."

Presented at the III European Congress of Family Therapy, Barcelona, October 2–5, 1997.

Address correspondence to Mark Beyebach, Universidad Pontificia Salamanca, c/Compañía, S, 37002 Salamanca.

In addition, the study examined a variety of clinical and process variables found to be related to the outcome of solution-focused work in previous studies (e.g., pre-treatment change, negotiation of treatment goals, and session format [Beyebach, Rodríguez Morejón, Palenzuela, & Rodríguez-Arias, 1996]).

SAMPLE

The sample in this study consisted of 83 cases seen between October 1992 and March 1996 at the Family Therapy Center (FTC) of the Universidad Pontificia de Salamanca (Spain). Services at FTC are offered free-of-charge, and clients are referred by former clients, physicians, psychologists, psychiatrists, and social workers. The center offers a postgraduate training program in SFBT. In the study sample, 61% of the cases were seen by trainers and 39% by trainees. The entire training group supervised all cases. All therapists in the study were postgraduate psychologists. Trainers had an average clinical experience of 8 years; trainees had participated for at least 1 year in an intensive training program.

Clients in the study sought treatment for a variety of reasons (see Table 1). In 29% of the cases, the client came with a psychiatric condition diagnosed by another mental health professional (i.e., depression, agoraphobia, schizophrenia). Fifty-six percent of the clients consulted for a problem presented by an adult while 44%, for a problem presented by a child or adolescent. Thirty-seven percent of the sessions were individual and 63% conjoint.

TREATMENT

Treatment followed the SFBT model as described by de Shazer (1985, 1988, 1991, 1994) and others (de Shazer et al., 1986; O'Hanlon & Weiner-Davis, 1989). Occasionally, techniques from the M.R.I. (c.f., Fisch, Weakland, &

Table 1. Distribution of the Sample in Terms of Presenting Complaints, as Rated on the PPCS

Type of Complaint	Percentage
Behavior problems with children	20%
Depressive problems	16%
Anxiety problems	22%
Marital problems	13%
Parent–child communication problems	13%
Addictions	4%
Other	12%

Segal, 1982) and narrative approaches (c.f., White, 1995; White & Epston, 1989) were integrated into the work when the SFBT approach did not seem to fit with the client (Beyebach & Rodríguez Morejón, 1998; Rodríguez Morejón & Beyebach, 1994). On a few occasions, some concepts and techniques from structural family therapy and psychoeducational approaches were used to complement the therapy.

Based on published criteria, the treatment provided in this study can be considered solution-focused (de Shazer & Berg, 1997). For example, the "Miracle Question" was asked in 89% of first sessions (when it was not asked, it was usually because most of the session focused on amplifying pre-treatment changes), "scaling questions" were asked in 65% of the sessions, and an "intersession" break was taken in 100% of the sessions followed by the delivery of compliments and a homework task.

INSTRUMENTS

Classification of the Presenting Complaint

The complaints presented by clients were classified by two independent judges using the "Sistema de Clasificación de los Problemas Presentados" (Presenting Problem Classification System [PPCS]). Reliability of the classification system was satisfactory, with two judges agreeing 85% of the time. When there was disagreement, the first author classified the case.

First-Session Rating Questionnaire (FSRQ)

Two independent judges completed this questionnaire after reviewing the videotape of the first session of treatment. The measure gathers information on (1) the clients' description of their problem (complaint); (2) any diagnosis reported by the clients that was given to them by another mental health professional; (3) clients' report of any medications they are taking related to their complaint; (4) clients' goals as given in response to the "Miracle Question"; (5) clients' report of pre-treatment change; (6) client–therapist relationship type (e.g., visitor, complainant, or customers); and (7) clients' answer to scaling questions.

Last-Session Rating Questionnaire (LSRQ)

Two independent judges completed this questionnaire after reviewing the videotape of the last session of treatment. The questionnaire gathers information on (1) whether clients talk about their initial complaint(s) in the past tense; (2) clients' report of goal attainment; (3) judges' perception of degree of problem resolution; (4) judges' perception of any new problems; (5) nature of termination (i.e., mutually agreed upon, or unilateral [e.g., dropout]).

Follow-Up Questionnaire (FUQ)

This 12-item questionnaire was administered to clients over the phone. The instrument was developed for the purpose of this study using questionnaires from previous outcome studies on SFT (de Shazer et al., 1986; de Jong & Hopwood, 1996; Riikonen, 1995).

PROCEDURE

Follow-up phone calls were conducted between May 1996 and September 1997. In 80% of the cases, at least 1 year had elapsed since the last session. In the remaining 20% of the cases, less than 1 year but at least 6 months had passed. On average, the time span between last sessions and follow-up was 23 months. In 18 out of the 83 cases, no follow-up was possible—telephone numbers were either missing or unavailable, or the clients had moved. For these cases, only the outcome at termination was measured. In two additional cases, a follow-up contact was made, but the clients refused to answer the questionnaire. These cases were categorized as failures. Clients seen in conjoint sessions were interviewed separately.

First- and Last-Session Rating Questionnaires were completed by two independent judges (both different from the follow-up interviewers and unaware of the follow-up results). In 16 out of the 83 cases, it was not possible to complete the LSRQ as videotapes were not available (some last sessions had not been taped, some tapes were accidentally erased or lost). For these cases, only the FUQ could be taken.

RESULTS

Outcome

LSRQ: Outcome at Determination

In the last session, 42% of the clients talked about their complaint in the past tense. Goals had been reached in 80% of cases and judges deemed the complaint either resolved or improved in 65% of the cases. When dropouts were excluded, these scores increased to 51%, 84%, and 73%, respectively. Sixty-six percent of the cases met at least two of the three criteria indicative of success, and were therefore considered "successful" at termination.

FUQ: Outcome at Follow-Up

On the follow-up questionnaire, 100% of the clients said they felt "very much satisfied" or "satisfied" with the treatment they had received. Ninety percent

considered the therapy as "useful" or "very useful." Eighty-two percent of the clients stated that their problem was solved (totally or partially) during therapy, and only 11% reported having consulted another mental health professional in relation to the complaint that had brought them to therapy.

Scaling Question

The average score on the scaling question for the whole sample was 4.2 in the first session (sigma = 2), 7.2 (sigma = 1.8) in the last session, and 7.1 at follow-up (sigma = 2.2). At follow-up, 71% of clients rated themselves at a 7 or higher on the scale, and only 14% rated themselves at a 4 or less.

Based on previous outcome studies of SFT (de Shazer et al., 1986; de Jong & Hopwood, 1996; Riikonen, 1995), cases were rated "successful" at follow-up if they had met all of the three following criteria: (1) a score of at least a 5 on the scaling question; (2) a scaling score higher than in the first session; and (3) the clients report that they had not consulted another mental health professional for the same problem as their initial complaint. Given these criteria, 74% of the total number of cases were successful when followed-up—a number that increases to 76% when dropouts are excluded.

Number of Sessions

For the whole sample, the average number of sessions was 4.67 (SD = 2.77). The modal number of sessions was 2. Twenty-eight percent of the cases came only once or twice, 70% had 5 sessions or less, and only 30% came for more than 5 interviews. When dropouts were excluded, the average number of sessions increased to 5.64 (SD = 2.73), with 55% of those who continued having 5 or less sessions. Cases deemed "successful" at determination averaged 5.82 sessions, whereas unsuccessful cases averaged 4.19 visits. Excluding dropout cases, a larger number of sessions correlated positively with outcome at termination ($r^2 = 0.50$, $p < .01$), although not with outcome at follow-up.

FSRQ: First-Session Variables

Most of the items on this measure bore no relationship to treatment outcome (medication status, psychiatric diagnosis, relationship type, individual versus conjoint sessions, and number of treatment goals). Cases with a personal complaint were significantly more successful than those with interpersonal complaints (84% versus 48%, chi square = 7.61; $p < .006$). Further analysis found that this difference was largely the result of the high success rate for "anxiety" and "mood problems," and the low rate of success for marital problems and "parent–child communication problems" (Tables 2 & 3). Though not statistically significant, there was a trend toward success for cases reporting pre-treatment change (77% versus 55% [chi square = 3.36; $p < .07$]).

Table 2. Percentage of Successful and Unsuccessful Cases at Termination for Different Types of Complaint (PPCS)

	Children	Depression	Anxiety	Marital	Communication	Addiction	Others
Success	60%	88.89%	85.71%	40%	37.5%	66.67%	66.67%
Failure	40%	11.11%	14.29%	60%	62.5%	33.33%	33.33%

Table 3. Percentage of Successful and Unsuccessful Cases at Follow-up for Different Types of Complaint (PPCS)

	Children	Depression	Anxiety	Marital	Communication	Addiction
Success	69.23%	77.78%	90.91%	55.56%	72.73%	100%
Failure	30.77%	22.22%	9.09%	44.44%	27.27%	0

Regression analysis on number of sessions, type of complaint, experience of the therapist, and report of pretreatment change found only type of complaint and number of sessions reached significance, whereas pretreatment change and the score on the scale came close to the $p < .05$ level (see Table 4). Stepwise regression showed that the format of the sessions (individual versus conjoint) did not add to the variance explained by type of complaint (personal versus interpersonal) (see Table 5).

Table 4. Logistic Regression for Outcome at Termination

Variable	*b*	*SE*	*WALD*	*df*	*Sig*	*R*	*Exp*
Sessions	.255	.1201	4.518	1	.0335*	.179	1.2909
	−.617	.6231	.982	1			
Training	.4925	.5615	.7692	1	.3809	0	.611
	.9445	.4454	4.4957	1	.0034		
Format	−.757	.605	1.565	1	.2108	0	.468
	1.163	.512	5.54	1	.0232		
Complaint	−1.14815	.6154	5.7949	1	.0161*	−.2267	.2273
	1.4815	.6154	8.9428	1	.0028		
Pretreatment	1.0986	.5870	3.2526	1	.0713	.1295	2.88
	.1942	.3609	.2894	1	.5906		
Scaling question	.304	.1697	3.215	1	.073	.1384	1.3557
	−.3978	.6946	.3280	1	.5669		

Table 5. Stepwise Regression for Outcome at Termination

Variable	*b*	*SE*	*WALD*	*df*	*Sig*	*R*	*Exp*
Complaint	−1.6521	.7522	4.8240	1	.0281*	−.2046	.1916
Format	.3292	.7920	.1728	1	6.776	0	1.389

Outcome and Dropout

Twenty-nine percent of the clients dropped out of treatment. Drop-out rates did not differ significantly for expert versus trainee therapists, though there was a clear trend favoring expert therapists (20% versus 42% [chi square = 4.54; $p < 0.33$]).[1] Sixteen percent of clients dropped out of treatment early—defined as clients who terminated unilaterally after the first or second session (13% for expert therapists, 21% for trainees, which is a non-significant difference). There was also a trend toward better outcomes between drop-out and non–drop-out cases, with continuers tending to be more successful than terminators (74% versus 36%, chi square = 5.63; $p < .02$). Although it doesn't rise to the level of statistical significance, a similar trend emerged for early dropouts (66% for non–drop-outs and 50% for drop-outs [chi square = .42; $p < .55$]). The variable that best distinguished between drop-outs and continuers was the client's answer on the FUQ about whether their problem was resolved during therapy. Only 55% of drop-outs considered their problem solved or improved at termination versus 89% of continuers (chi square = 7.34; $p < .007$).

Outcome and Therapist Experience

No statistically significant differences were found between expert and trainee therapists in the percentage of successful cases at termination (experts = 61%, trainees = 72% [chi square = .78; $p < .38$]; excluding dropouts: experts = 71%, trainees = 80% [chi square = .43; $p < .51$]), or in the percentage of successful cases at follow-up (experts = 79%, trainees = 67% [chi square = 1.16; $p < .28$]; excluding dropouts: experts = 81%, trainees = 74% [chi square = 2.54; $p < .21$]).

Outcome at Termination and Outcome at Follow-Up

Outcome at termination and outcome at follow-up were positively correlated (chi square = 6.9; $p < .009$). Eighty-four percent of cases categorized as successful at termination were still rated successful at follow-up, whereas 16% of successful cases at termination were rated as unsuccessful at follow-up (relapse). On the other hand, 47% of the cases rated as failures at the end of therapy were found to be successful at follow-up.

[1]Experimentwise-alpha has been adjusted to more conservative $p < .01$ rather than the usual $p < .05$ to correct for the multiple statistical contrast performed in this study.

DISCUSSION

Several aspects of this study limit the generalizability of the results. First and foremost, the lack of a control group in this study makes it impossible to claim that the outcomes specifically are due to SFBT. Client changes may just as well be due to factors unrelated to therapy (i.e., maturation, influence of other persons, situational changes, etc.). Another serious shortcoming of this study is the largely unknown reliability and validity of the instruments used. Furthermore, the description of the sample in terms of the presenting complaint (as opposed to, for instance, using DSM-IIIR criteria) makes comparisons with research completed on other treatment modalities difficult if not impossible. Finally, as noted earlier, the treatment used in this study was neither "pure" SFBT or manualized.

With these caveats in mind, some interpretations and provisional conclusions are possible. To begin, the findings of this study resemble those of our previous studies (Beyebach, Rodríguez Sánchez, Arribas de Miguel, Hernández, Martín, & Rodríguez Morejón, 1996; Beyebach, Rodríguez Sanchez, Arribas de Miguel, Hernández, Herrero de Vega, & Rodríguez Morejón, 1997), as well as the results of other uncontrolled studies done by other researchers (de Shazer et al., 1986; De Jong & Hopwood, 1996; Fontecilla, Ramos, & Rodríguez-Arias, 1995; Riikonen, 1995). On average, the cases in this study improved 3 points on the progress scale from the first to the last session. This compares favorably with the results reported by De Jong and Hopwood (1996). The percentage of successful cases fell between that reported by MacDonald (1997) and de Shazer (1988). The average length of treatment was slightly longer (4.67) than the average reported by de Jong and Hopwood ([2.9] 1996) and MacDonald ([3.6] 1997) but comparable to other studies in the literature (de Shazer, 1988; Fontecilla, Ramos, & Rodríguez-Arias, 1993).[2]

Changes reported during therapy were remarkably stable. At follow-up, for example, three out of four clients maintained a 7 or more on the progress scaling question. Only 1 out of 10 clients sought additional assistance from another mental health professional. Seventy-four percent of the cases (79% of those seen by expert therapists) were considered successful at follow-up. Taken together,

[2]It should be remembered that these comparisons are done in a very general sense, as we cannot assume that the samples are in any way comparable. Differences in outcome or in the number of sessions might well be due to differences in the severity of problems, the therapeutic setting, the way SFT was used, etc.

such data strongly suggest that changes that occur during SFBT are robust and durable.

The only variables found to be statistically associated with outcome at termination were the type of complaint (more success with "personal" than with "relational" complaints) and number of sessions (more sessions were associated with a better outcome). With regard to the first variable, the success rate for complaints considered personal (84%) was higher than for those considered relational (48% success). This is an intriguing finding not only because it is the first time a study of SFBT has found problem type related to outcome, but also because SFBT is frequently seen as "systems oriented," and therefore might in principle be thought of as being *more* effective with relational complaints. There are several possible explanations for this finding. First, the distinction between relational and personal complaints was not theoretically or clinically derived, but rather imposed to make statistical analysis easier in our pilot study (Beyebach et al., 1996). As such, the finding may represent more statistical artifact than any clinically or theoretically meaningful categorization. A more parsimonious explanation, however, is that the data are simply a reflection of the high rate of success (in any form of therapy) for anxiety and mild depressive problems (in our sample, 78% and 91% success at follow-up) and the low success rate reported for marital therapy (Alexander, Holtzworth-Munroe, & Jameson, 1994). A third possibility, namely that the better results for "personal" complaints were due to the effect of the variable "therapy format" (with non-conjoint sessions hypothetically being "easier" to handle) could be ruled out on the basis of our stepwise regression analysis.

With regard to length of therapy, successful cases tended to have more sessions (5.8) than unsuccessful ones (4.2). This finding is consistent with previous studies on SFBT (de Jong & Hopwood, 1996; Kiser, 1988, cited in De Jong and Hopwood, 1996) and can be taken to mean that briefer is not necessarily better. Indeed, the consistency of this finding across studies of SFBT suggests that it might be better to keep clients a little bit longer in treatment rather than to pressure them to terminate quickly (Metcalf, Thomas, Duncan, Miller, & Hubble, 1996). At the same time, however, it must not be forgotten that the direction of causality is not entirely clear. It could be, for example, that clients stay longer in treatment *because they are feeling successful* (and, for instance, feel motivated to report to their therapist on the positive developments in their situation) rather than being more successful because of a longer treatment.

Two clinical variables previously found to correlate with outcome (Rodríguez Morejón, 1994; Beyebach, Rodríguez Morejón, Palenzuela, & Rodríguez-Arias, 1996) showed no statistically significant association in the present study. The first, pretreatment change showed a tendency toward being associated with outcome and might have reached statistical significance with a larger sample.

The second variable, well-formed goals (defined as "at least three behaviorally defined goals"), made no difference at all. This latter (non)finding, however, may have less to do with the importance of goals in SFBT than with the fact that nearly all cases (89%) had well-defined goals. The same explanation likely accounts for the failure to find a relationship between outcome and "relationship type." In the study, 92% of clients were categorized as customers. In future studies, it might be more useful to define these variables differently.

No significant differences in the therapeutic outcome were observed for clients seen by expert therapists versus those seen by trainees. This could be seen as a consequence of the small number of cases or the instruments used in this study. At the same time, however, it may also reflect the skill level of trainees who, it will be recalled, had followed an intensive, one-year-long, practice-oriented training program. Another possibility is that the live supervision of all cases may have ensured a homogeneous level of performance by both the trainees and their trainers. The fact that early drop-out rates were twice as high for trainees as for expert therapists remains puzzling. Although it does not rise to the level of statistical significance, this question deserves further investigation.

The study also found no differences in outcome between clients that dropped out of therapy and those that terminated by mutual agreement with their therapists. However, the finding that 89% of non–drop-out clients reported that their problems improved during therapy, whereas only 55% of drop-out cases do, suggests that these two groups of clients follow different processes of change. In other words, clients who drop out get less out of therapy and change later on their own, whereas those who continue in therapy experience most of their improvement while in treatment. Only a closer look at the temporal process of these changes would allow us to confirm which view is accurate.