SFBT Outcome Studies
by Insoo Kim Berg

Because the model developed deductively, that is, first try something, then see if that worked, try to describe it in detail, etc., the SFBT (Solution-Focused Brief Therapy) approach can be described as experimental and research oriented from the beginning. Years later when we read what Lincoln and Guba (1985) wrote about "naturalistic inquiry," we saw that what we were doing was sufficient in itself as a research endeavor.

We started out by seeing clients in our living room with the video camera (and operator/team member) on the landing of our stairs, the consulting break was taken in one of the upstairs bedrooms. We were interested in finding out what differences made a difference and were not at all interested in proving anything to the outside world. Now that the approach is becoming more accepted by academia, including those with scientific minds and backgrounds in traditional research methods, it is coming under the same kind of scrutiny as other approaches and is being measured by the standard ways of assessing effectiveness. We not only lacked the resources to undertake such studies, but the basic assumptions and premises of the two worlds clashed. Being clinically oriented, we were more than satisfied with our naturalistic research projects.

Although SFBT has begun to develop in 1978 and we gave the name SFBT in 1982, research into the approach - other than our own exploratory and experimental, model/theory construction research projects (de Shazer, 1985, 1988, 1991, 1994) and our own follow-ups - have been minimal. Primarily this is due to BFTC's having been a teaching, and training focused endeavor. We and our clients were busy inventing a rather radical approach to 'therapy'. We were interested in 'searching' for and finding out what works and were not at all interested in questions about whether the approach works 'as well as' or 'better than' other approaches.

We have always been interested (more likely were obsessed with) the question 'What works' (so that we could do more of it) rather than is's opposite. None the less, we carefully watched our failures. We wondered if there was some way to predict failure, some contra-indications, but we were never successful in this effort. Perhaps surprisingly, in our most recent follow-up study, we again learned that diagnosis does little to predict outcome and, in fact, the SBFT is consistently successful - regardless of the client's problem(s) (DeJong & Berg, 1997). This is what led us to draw our radical distinction between 'problems' and 'solutions'. Furthermore, we surprised ourselves by proving one of our own assumptions wrong: the presence or absence of a team behind the one-way screen has no impact on outcomes (Burr, 1990).

Of course we had realized all along that SFBT is not a panacea and is not the answer to all the many and varied ills to which human beings are subject. Our follow-up studies, i.e., asking clients whether they met their goals, are not earth shaking. Of course, what is surprising is that in recent years, the average number of sessions per case has dropped, to almost 3 sessions (DeJong & Berg, 1997). All therapy models work and many clients report that they benefited simply from talking to a therapist. One result of this is that we continued to work with our general outpatient clinic population (with no screening of clients) and thus did not seek to apply the approach to any of the standard problem-defined population until quite recently (Berg & Miller, 1992; Berg & Reuss, 1997).

In creasing frequency, I am asked about the outcome studies that show effectiveness of SFT and with equal frequency, I am contacted by students, both in masters and doctoral levels, researchers, grant writers, all of whom need to document or is curious about whether SFT is effective in producing desired outcome. This is

a difficult question to answer for any therapy models, yet I believe this is one of many signs that we are becoming more of a mainstream than ever before.

For those of you who are seeking such information, I am posting here those studies that are known to me personally (I am sure there are many that I don't know about yet). My understanding is that such studies are increasing and that there are many researchers, such as Cynthia Frankly, Ph D of University of Texas at Austin, TX who is a top notch researcher are looking into the effectiveness of the SFBT in a systematic manner with her masters and doctoral students.

For those of you who are interested in gathering further information, please contact- Dr. Alasdair Macdonald at AJMacdonald@compuserve.com who is the coordinator of research of European Brief Therapy Association.

Outcome Studies on Solution-Focused Therapy

1. David Kiser, (1988). A follow-up study conducted at the Breif Family Therapy Center. Unpublished manuscript.

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2. Kiser, D. & Nunnaly, E. (1990). The relationship between treatment leangth and goal achievement m solution-focused therapy. Unpublished manuscript.

for further information on these unpublished manuscripts, contact David Kiser at:

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3. Steve de Shazer, (1991) Putting Difference to Work, W. W. Norton

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Contact Steve de Shazer at:
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4. Peter DeJong & Insoo Kim Berg, "Solution-Building Conversations-Co-constructing a sense of Competence," In Families in Society, June, 1996 issue. page 17 in paper:

details of this latest study (1996)
N=275
Population studied - general clinic population, no screening
Age range: 2 - 60
57% - African-American (self identified)

5% - Latin
3% - Native-Amencan
36% - White
60% female, 40% male
43% employed, 57% unemployed
Diagnotic catagories: wide ranging, from depression, job related problems, violence, sexual and substance abuse, personality disorder, ADHD, and schizophrenia.

Potential range on scales of -10 to 10. In reality they ranged from -3 to 8 on intermediate outcome.

-3 - 0: no progress, 1-3: moderate progress, 4-8: stgnificant progress.

26% reported no progress; 49% moderate progress; 25% sagnificant progress.
Average number of sessions - 3
Median number of sessions - 2

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5. Study by Alasdair Macdonald, MD in Scotland shows the following results:

Population studied: Persons who are diagnosed as having schizophrenia
Number seen: 44
Follow-up number - 41
Average number of sessions 5.7

women seen overage number of sessions - 5 or 6; men - 2
Clients reporting "good outcome" 67%

Clients with clear goals - average of 3 or 4 sessions
Conclusion: positive goals are best, and any goal is better than none.

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6. Lotta Lindforss of Stockholm, Sweden

Population: Prison population with criminal acts and substance abuses

Study design: Comparison between controlled group who received regular treatment of prison system and experimental group treated with solution-focused therapy. Average number of sessions: 4.5

Follow-up study conducted at 6, 12, 18 months after release from prison
Those treated with SFT had 20% lower rate of recidivism and committed fewer and less serious crimes, such as assault against property instead of against persons.
After 6 months 40% of experimental group were still outside pluson while in the control

group, only 14% were outside the prison.

Details of the study will be published in November/December, 1996 of Contemporary Family Therapy (guest editors: Insoo Kim Berg & Steve de Shazer).

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104 30 Stockholm, Sweden

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7. Mark Beybach, Salamanca, Spain

39 cases studied in typical out-patient mental health setting.
Average number of seestons: 5 (33 minutes m length on average)

80% reached their goals
Findings: concrete, specific goals AND presence ofpretreatment change were predictive of outcome.

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