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GUEST EDITORIAL

An Update on Strengths-Based, Solution-Focused Brief Therapy

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In this editorial I challenge social workers to continue to value and practice the specific interventions that were developed in social work by MSWs and our academics. Specifically, I want to bring to the attention of the readers of the *Health & Social Work* journal the continued significance of the strengths perspective and also to update you on the progress and the research of one strengths-based approach, solution-focused brief therapy (SFBT), that is particularly useful in the practice of health and mental health recovery.

Since the very early history of the social work profession, educators like Bertha Capen Reynolds, Virginia Robinson, and Helen Harris Perlman developed practice approaches that emphasize strengths, resources, and the self-determination of the client. More contemporary theorists like Ann Weick and Dennis Saleebey popularized this work into the strengths perspective and, like their predecessors, also criticized approaches that overly pathologized clients and relied exclusively on the medicalization of client problems (Saleebey, 2012; Weick, Rapp, Sullivan, & Kisthardt, 1989). Instead, the strengths perspective incorporated the humanistic values of the social work profession and provided a unique framework for solving problems that focused on the resources of clients and their social environment—a focus on goals; creating a hopeful future; personal choice; and a collaborative, empowering relationship between social workers and clients. Proponents of the strengths perspective used this framework to facilitate changes in individuals and families, in the community, and within the systems of care such as mental health services, schools, and child welfare practice (Kim, 2008b).

In 2005 Rapp, Saleebey, and Sullivan wrote an article addressing the future of the strengths perspective, suggesting that more rigorous research and a grounding in social work practice interventions was important for this approach to move beyond just being a framework that social workers valued. These authors identified core elements of the strengths perspective, illustrating each element with specific practices that they believed embodied the strengths-based model. One approach these authors identified is SFBT. SFBT is a strengths-based intervention that was developed in the early 1980s by two social workers, Steve de Shazer and Insoo Kim Berg, along with a team of interdisciplinary colleagues at the Brief Family Therapy Center in Milwaukee. Although mostly associated with clinical practice, this approach has also been used in coaching, organizational consulting, and management (Franklin, Trepper, Gingerich, & McCollum, 2012). SFBT provides specific interventions that help people explore resources and past successes, and identify goals and future hopes and solutions to their own problems. Also, consistent with the strengths perspective, at the core of SFBT is the client-centered, collaborative relationship between the client and the social worker. Social workers who use SFBT make use of specifically designed language skills and techniques to affect psychological meanings, social interactions, and behaviors, and enable clients to discover their own solutions. They also work with all the resources available within the client and their social context.

EMERGING EVIDENCE BASE FOR SFBT

One of the criticisms of the strengths-based approaches is that they have not been tested using rigorous research designs. Fortunately, however, more rigorous research has been accumulating on SFBT over the past decade as this approach is being examined using randomized controlled trials (RCTs) and quasi-experiments. The growth of studies on SFBT in both numbers and quality suggests that SFBT is a practice based on evidence, although there is still a need for more RCT studies with larger samples (Kim, Trepper, Smock, McCollum, & Franklin, 2010).

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The research committee for the Solution-Focused Brief Therapy Association, of which I am the current chairperson and have served on as a member for 10 years, has worked to communicate the studies on SFBT to federal agencies. Studies on SFBT group interventions with adult mental health clients with mild substance use issues and interventions for older populations with health, psychosocial, and mental health concerns have been reviewed by the Substance Abuse and Mental Health Services Administration, resulting in the inclusion of SFBT in the National Registry of Evidence-based Programs and Practices as a promising practice (http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=Solution-focused%20brief%20therapy).

To further communicate the growing research on SFBT, I also worked with a team of researchers and practitioners from different countries to develop the book, *Solution-Focused Brief Therapy: A Handbook of Evidence-Based Practice* (Franklin et al., 2012). This book includes a treatment manual on SFBT; strengths-based assessment tools; and a summary of the systematic reviews, meta-analyses, and other studies on SFBT. The book itself was an idea of the SFBT developer Insoo Kim Berg, who believed research studies on SFBT were accumulating in different countries and that a resource book would be a good way to communicate to practitioners the work of researchers across the globe. I discovered that SFBT is being practiced and researched in many different countries, including diverse European nations, Canada, Australia, Japan, Korea, China, Singapore, Taiwan, and Mainland China. Another good source for keeping up with research on SFBT in different countries is the SFBT Evaluation List that was developed by a psychiatrist in the United Kingdom, Alasdair MacDonald. This free Web site compiles annotations of the research on SFBT across many different settings (http://www.solutionsdoc.co.uk/sft.html).

WHAT DO THE REVIEWS OF RESEARCH SAY ABOUT THE PRACTICE OF SFBT?

Meta-analyses and systematic reviews are considered to be at the top of the research hierarchy. The purpose of a meta-analysis is to systematically collect data from multiple studies that answer a specific research question (for example, "How effective is SFBT?") and offer a quantitative number that statistically illustrates how effective a particular variable (for example, receipt of solution-focused therapy) is on identified outcomes (for example, depression of clients in therapy). Even though meta-analysis is considered to be at the top of the hierarchy and an acceptable way to evaluate interventions, it is not independent of other research and is limited by the studies that are available to include in the analysis, so the reviews that we do have on SFBT are limited by the number and quality of studies. As mentioned, however, the quality of the studies has improved substantially over the past 10 years when compared with the previous state of the research.

The first meta-analytic review of SFBT was conducted by Dutch researchers with the aim of investigating the effectiveness of SFBT with various populations (Stams, Dekovic, Buist, & de Vries, 2006). In this review, 21 studies met inclusion criteria. The pooled effect size using the random effects model was $d = .37$ (95% CI, $19 < d < .55$), $p < .001$ ($Z = 3.94$), indicating that those who had received SFBT reported outcomes that had a small to near medium effect. Researchers, however, found the sample of studies to be heterogeneous [$Q(20) = 63.87$, $p < .001$]. Moderator analysis was conducted to address the heterogeneity of studies. The moderator analysis results indicated that when compared with a group who received no treatment, those who received SFBT were found to have a statistically significant medium effect size ($d = 0.57$, $p < .01$). The moderator analysis further highlighted that studies published prior to 2000 did not produce effects ($d = .29$, $p < .001$) as strong as those published after 2000 ($d = .87$, $p < .001$). In addition, some specific populations benefited more from receiving SFBT: adults ($d = .87$, $p < .001$), clients who received services while being institutionalized ($d = .60$, $p < .001$), participants with externalizing problems ($d = .61$, $p < .001$), those who received SFBT in a group format ($d = .59$, $p < .001$), and participants who received six weeks or less of SFBT ($d = .46$, $p < .001$).

In the United States Kim (2008a) conducted a meta-analysis that included 22 SFBT studies that met inclusion criteria. Kim's (2008a) results revealed a small and non–statistically significant overall effect size ($d = .13$). Kim also investigated specific studies that affected internalizing, externalizing, and relationship dimensions and found that SFBT had a small, statistically significant effect on internalizing disorders ($d = .26$, $p < .05$).

In a more recent qualitative, narrative review, Gingerich and Peterson (2013) sought to correct some of the weaknesses of other quantitative reviews of SFBT by including broader search criteria, such as

searching for studies in different languages and using a more focused search strategy that included an emphasis on unpublished studies and better-defined outcome criteria. These authors identified 43 studies that existed across six distinct fields of practice, including health and mental health care, showing a wide variation in applications that varied from youth to old age. Of the 43 studies analyzed, Gingerich and Peterson (2013) reported that 32 (74 percent) received

> significant positive benefit from SFBT, and an additional 10 (23%) reported positive trends. Only one study reported no observable benefit from SFBT. Limiting the analysis to only randomized studies, 20 of the 24 (83%) showed significant benefit from SFBT, suggesting that the better-designed studies provide the strongest evidence of effectiveness. (p. 279)

A particular area of efficacy for SFBT was reported to be in the treatment of adult mental health clients with depression.

The Gingerich and Peterson (2013) study reviewed some international studies from China and Korea but did not specifically analyze the different results achieved with diverse ethnic groups or address the effectiveness of SFBT with Asian populations. In an attempt to address the evidence for SFBT with Asian populations, Kim et al. (in press) examined studies from China. This meta-analysis included nine studies and showed that outcome studies on SFBT in China have medium to very large treatment effects for internalizing problems such as depression, anxiety, and self-esteem. When effect sizes across all nine studies were combined, the meta-analysis results showed very large effect size estimates ($g = 1.262$, $p < 0.001$) and statistically significant differences in treatment effects favoring SFBT. The overall results highlight the positive impact SFBT has on Chinese clients with mental health–related problems.

A few other systematic reviews of SFBT interventions that focus on youths in schools and family services have also been completed (for example, Bond, Woods, Humphrey, Symes, & Green, 2013; Corcoran, 2012; Kim & Franklin, 2009). These reviews have shown that SFBT is a promising treatment for emotional, behavioral, and academic problems in schools and may be most effectively used in early intervention.

CONCLUSION

In this editorial I discussed the importance of the strengths perspective to the field of social work and challenged practitioners to continue to value and practice interventions that were created by social workers. In particularly, I have reviewed updates on the progress and research of the strengths-based SFBT. Over the past few years the field has witnessed the deaths of several social workers who were developers and leaders of the strengths-based approaches, including Dennis Saleebey, Ann Weick, Steve de Shazer, and Insoo Kim Berg. The loss of these leaders suggests that the torch is being passed to a new generation, and it will be up to others to advance strengths-based models.

The evidence for strengths-based SFBT is growing, suggesting that this approach is advancing and that social workers can confidently use SFBT when their clinical judgment and client situations suggest that it may be useful. Right now, some tentative themes are emerging in SFBT research. Studies have shown that SFBT performs as well as other psychotherapies, such as cognitive–behavioral therapy, in research studies for adult depression. In addition, research from various countries suggests that internalizing disorders (for example, depression, anxiety, and stress) is an area in which SFBT may work well with youths and adults, and SFBT may also be helpful in increasing medication compliance. In addition, SFBT has been successfully used in training interprofessional teams to be more effective in interviewing and communicating with clients in health care and school settings. Moreover, when providing therapy for Asian populations, social workers may consider using SFBT because studies suggest that SFBT is being successfully applied in diverse Asian countries, such as Taiwan, China, Japan, and Korea, with promising results (Franklin & Montgomery, 2013; Franklin et al., 2012; Zhang et al., in press). Finally, both research and clinical experience suggest that school mental health settings, child protection, and other youth and family services are settings in which SFBT may work well. I hope social workers will learn more about SFBT and will continue to see the advantages of the strengths-based approaches in their work. HSW

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