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A STUDY OF SOLUTION-FOCUSED BRIEF FAMILY THERAPY: OUTCOMES AND ISSUES

MO-YEE LEE

This article discusses the findings of a descriptive study on solution-focused brief family therapy in a children's mental health facility. Findings indicate a 64.9% success rate for an average of 5.5 therapy sessions over an average of 3.9 months. In addition, findings provide initial support for the applicability of solution-focused brief family therapy to a wide range of families from diverse backgrounds as well as to the practice of working with whoever comes to therapy. The study also introduces thought-provoking theoretical and clinical issues regarding helpful versus unhelpful therapy processes and the influences of problem nature and selected goals on therapy outcomes.

During the past decade, there has been an explosion of interest in short-term therapy. In reaction to the comparatively long-term psychoanalytically based therapeutic models, theorists adopting a strategic and systemic approach—such as Milton Erikson, Jay Haley, Paul Watzlawick, and Steve de Shazer—have developed different theories regarding the process of change and problem maintenance. They provide a theoretical base for therapists to develop a short-term approach to therapy. Ventures into brief therapeutic approaches are further supported by encouraging research findings that such an approach can be effective for producing favorable outcomes and for using agency resources (Chubb & Evans, 1990). With managed health-care policies emphasizing the cost-effectiveness of treatment and many studies indicating that the average number of treatment sessions that clients attend is only six (Garfield, 1989), brief family therapy appears to be a viable treatment method for working with families.

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Solution-focused brief family therapy is one of the short-term therapies that has experienced increased popularity in the field. Despite its popularity, very little research has been conducted on solution-focused therapy. The two most prominent published studies were conducted at the Brief Family Therapy Center in Milwaukee (de Shazer et al., 1986; de Shazer, 1991). The first study reported a success rate of 72%, and the second study reported a success rate of more than 80%, based on clients' self-reports. These investigations focused on clients' evaluation of goal attainment and changes associated with the therapy.

The present study attempts to evaluate the effectiveness of solution-focused brief family therapy in a children's mental health facility. The other purpose is to explore two questions regarding solution-focused brief family therapy: 1) What are the relationships between respondents' reported goals and family presenting problems? 2) What are the relationships between goal attainment, children and family variables, and therapy variables? The first question is relevant to further our understanding of the theoretical and clinical focus of solution-focused brief family therapy on goals instead of problems. The second question attempts to explore factors associated with positive therapy outcomes.

SOLUTION-FOCUSED BRIEF FAMILY THERAPY

Different from a problem-based approach, solution-focused brief family therapy focuses on finding solutions and gives minimal attention to defining or understanding presenting problems. Such a theoretical orientation is based on a systems perspective (Bateson, 1972) and social constructivism (de Shazer, 1988; Efran, Lukens, & Lukens, 1988). Solution-focused brief family therapy views problems as being developed and maintained within the context of human interactions. The task of therapy, therefore, is to help clients do something different by changing their interactive behaviors or their interpretations of behaviors and situations so that a solution can be achieved (de Shazer et al., 1986). Influenced by social constructivism, solution-focused brief family therapy assumes that "the future exists in our anticipation of how it will be" (Cade & O'Hanlon, 1993, p. 109). Because problems and solutions are not objective realities but are subject to a person's construction and interpretation, there is no single solution to any problem. Further, solutions need not be directly related to problems (de Shazer, 1988). Consequently, therapy becomes a process in which both the therapist and client co-construct new, beneficial systems or frames that are conducive to problem resolution (Coyne, 1985).

In terms of the therapy process, clients were first oriented to a solution-focus frame. The focus of therapy was to help clients find solutions to their problems with as few sessions as needed. The clients were immediately encouraged to give a clear and explicit statement of their presenting complaint. Without focusing on the history of the problems, the therapist used exception questions, outcome questions, coping questions, scaling questions, and relationship questions to help clients identify solutions for their problems.

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Exception Questions

Influenced by a systems perspective, change is perceived as constant in a system. As such, every complaint pattern includes some exceptions to the rule. Such exceptions serve as clues to a solution (de Shazer et al., 1986). Exception questions inquire about times when the problem is absent, less intense, or dealt with in a manner that is acceptable to the client. Useful questions include: When don't you have this problem? When is the problem less bad? What is different about these times? (de Shazer, 1985). The therapist presupposes that change is happening in the client's problem situation. Such an effort shakes the rigid frames constructed by many clients with respect to the pervasiveness and permanency of their complaints.

Outcome Questions

Because the future exists in our anticipation of how it will be, clients will have a better chance to achieve their goal if they can clearly envision a future when they do not have the problem. The "miracle question" (de Shazer & Molnar, 1984) has commonly been used by therapists to help clients construct a vision of life without the presenting complaint: "If a miracle happened and you woke up tomorrow and your problem was solved, what would be the first small sign that tells you that a miracle has happened and your problems have been resolved, and what would be the first different thing that you would notice about yourself, your spouse, or your child?" The therapist needs to help clients think in terms of small, observable, and concrete behaviors so they can notice a small change that makes a difference in their situation (de Shazer, 1985).

Coping Questions

Because change is constant in a system, the therapist assumes that there are variations with respect to clients' coping abilities over the course of the problem. Coping questions ask clients to talk about how they manage to cope with and endure their problems (Berg, 1994). Clients are asked such questions as, "How come things aren't worse?" "What are you (or other family members) doing to keep it from getting worse?" The purpose is to indirectly reframe the meaning frames of clients who have assumed that they are entirely helpless and have no control over the problem situation.

Scaling Questions

The scaling question asks clients to rank their situation or goal on a 1-to-10 scale (Berg, 1994). Usually, 1 represents the worst scenario that could possibly be and 10 is the most desirable outcome. Scaling questions provide a simple tool for clients to quantify and evaluate their situation and progress so that they establish a clear indicator of progress for themselves.

Relationship Questions

From a systems perspective, a person never exists alone. Besides asking clients to establish concrete, precise indicators of change for themselves, it is always helpful to ask clients what their significant others think about their problem situation and progress (Berg, 1994). The establishment of several indicators of change helps clients develop a clearer vision of a desired future appropriate to their real life context. Examples are: "What would your mother [or spouse, sister, etc.] notice different about you if you didn't tell her that there's been a miracle?" "How would your wife (or other significant others) rank your motivation to change on a 1-to-10 scale?"

Besides using exception, outcome, coping, scaling, and relationship questions, solution-focused brief family therapy encourages clients to "think small." Based on a systems perspective, change in one part of a system leads to changes in the system as a whole. In this way, only a small change is necessary to lead to changes in the whole family as a result of the "butterfly" effect. When clients experience success in achieving a small change, they become more resourceful in finding solutions to other, more difficult problems (Walter & Peller, 1992). Therapy, as such, begins with the simplest solution, and complex problems do not necessarily call for complex solutions (de Shazer & Berg, 1985). Solution-focused brief family therapy practitioners also use task assignments in their interventions (de Shazer & Molnar, 1984; Kral & Kowalski, 1989).

In sum, solution-focused brief family therapy is not just a way of interviewing and intervention but also a way of thinking whereby clients' resourcefulness and their construction of their realities are fully respected. Therapy helps clients to meet their needs by utilizing what they bring with them.

THE STUDY

This was a one-group posttest design study conducted by the Brief Family Therapy Team at the C. M. Hincks Centre to examine the effectiveness of solution-focused brief family therapy based on clients' self-reports. The study defined "solution-focused brief family therapy" by its theoretical and practice orientations. Although the team had set no limitations on the number of sessions, each therapist informed clients during the first session that there would be as few sessions as they needed, and the focus of therapy was to assist them in finding solutions for their concerns in as few sessions as possible. The team met weekly to discuss practice and theoretical issues of solution-focused brief family therapy, as well as issues related to the research project.

Sample

All families receiving treatment from the team between 1990 and 1993 were included in the study. At termination, the families were notified that

08/28/2001 08:41 5122322165 UT SOCIAL WORK PAGE 05

an interviewer would phone them six months later to ask their opinions about the services they had received from the team. Participation in the research, however, was voluntary. Information from 59 families was available at the time of data analysis.

Procedures

A six-month follow-up phone call to each family was conducted by a team member who had no connection with and no knowledge of the family. A 14-item questionnaire was used to investigate clients' opinions about the services they had received from the team. The questionnaire was adapted from the one used by the Brief Family Therapy Center in Milwaukee (de Shazer et al., 1986). Such an approach gave the team a standard for comparison. The 14-item questionnaire focused on respondents' perceptions of the goals they had sought to attain through therapy, goal attainment, the current situation of their problems, the development of new problems, and the development of new positive changes. Other questions aimed to investigate respondents' perceptions of their experience of the therapy process. Respondents were asked about things the therapist had said or done that they found helpful and things they had found unhelpful. Information on clients' presenting problems and children and family variables were obtained from case files.

To analyze the data, a four-member committee was formed to develop a coding scheme based on answers provided by respondents during the telephone interviews and relevant information from case files. Appropriate codes were developed for presenting problems, respondents' reported goals, goal attainment, helpful elements of therapy, and unhelpful elements of therapy. Presenting problems included family relationship problems, behavioral problems at home, school-related problems, emotional regulation, self-esteem problems, parents' marital situation and / or children's coping, parenting skills, and problems with courts or police. Respondents' reported goals included improved family relationships, improved behavior at home, improved emotional regulation, improved school functioning, improved parents' marital situation and / or children's coping, improved parenting skills, self-development in parents, self-development in children, and enhancement of relationships between the family and larger systems. Goal attainment included goal met, goal partly met, goal not met, and unsure. Helpful elements of therapy were being supported / validated, useful feedback, educational, focus on the positive, focus on useful goals, opportunity to talk, and good questioning. Unhelpful elements of therapy included therapist being rigid, artificial, inflexible, too positive, or insensitive and client as not being supported or as bothered by the setting (e.g., one-way mirror, camera), as well as structural problems (e.g., timing, location). Except data on presenting problems that were extracted from case files, all information was based on respondents' reports.

Because coding was required to analyze the data, interrater reliability was computed using kappa statistics. Data on 20% of the sample were randomly selected and individually coded by two independent raters. The

two raters agreed on 88.2% for the presence of a specific variable and 81.3% for the absence of a specific variable. The overall agreement rate was 85.1%. Correcting for chance, the Cohen's kappa value was .81 ($p < .05$). The relationships between different variables were assessed by cross-tabulations.

FINDINGS

Sample Characteristics

A total of 59 children, aged 4 to 17, were included in the study. The mean age was 10.9 years (S.D. 3.5). A higher proportion of boys than girls received treatment from the team (71.2% versus 28.8%). Latency children between the ages of 7 and 11, and adolescents between the ages of 12 and 16, represented the largest proportion of the client population (35.6% and 44.0%, respectively). Families receiving services from the team had, on average, high education attainment. Seventy-five percent of the mothers and 71.1% of the fathers had received college or university degrees or higher education. The three most common occupations for the mothers and fathers were as managers and administrators (43.5% and 27.3%), professionals (23.9% and 36.4%), and service workers (17.4% and 18.2%). With respect to family structure, 31 children (52.2%) came from two-parent families. Nineteen (32.2%) and nine (15.3%) children came from one-parent and blended family situations, respectively.

Therapist Variables

Families receiving therapy were seen by either a team or an individual therapist. The teams were made up of one therapist in the room with the family and one or more therapists behind a one-way mirror. A team approach was more prevalent for the present study (79.7%). A similar number of families were seen by female and male therapists (52.5% and 47.5%, respectively). Both staff therapists and student therapists from accredited master-of-social-work programs provided treatment. All student therapists were supervised by staff therapists experienced in solution-focused brief family therapy.

Therapy Variables

The families came for an average of 5.5 sessions (S.D. 3.5) over an average of 3.9 months (S.D. 3.0). Involved in the therapy were 98.3% of the mothers, 40.7% of the fathers, 94.9% of the child clients, and 37.3% of their siblings. Extended family members and other service providers were minimally involved in the therapy. For 80% of the families, two or three members were involved in the therapy, usually mother and child.

The four most commonly reported presenting problems were "family relationship problems" (55.9%), "school-related problems" (42.4%), "children's behavioral problems at home" (39.0%), and "emotional regulation

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TABLE 1
Chi-Square Results of Presenting Problems and Goal Attainment (N = 49)

Presenting Problems	Frequency (%) (N = 59)	Goal Attained* Problem Present (N)	Goal Attained* Problem Not Present (N)
Family relationship problems	55.9	48.3 (29)	85.0 (20)**
School-related problems	42.4	66.7 (18)	61.3 (31)
Behavioral problems at home	39.0	60.0 (20)	65.5 (29)
Emotional regulation problems	35.6	100.0 (17)	43.8 (32)**
Parents' marital situation and / or children's coping	10.2	50.0 (6)	65.1 (43)
Parenting skills	10.2	60.0 (5)	63.6 (44)
Problems with courts, police	3.4	0.0 (2)	66.6 (47)

*Ten cases were discarded owing to missing information on goal attainment.
** $p < .05$.

problems" (35.6%) (see Table 1). On the whole, all families reported an average of two presenting problems.

At the six-month follow-up telephone interview, the four most commonly reported goals were "improved family relationship" (44.1%), "improved children's behavior at home" (37.3%), "self-development in parents" (22.0%), and "improvement in parents' marital situation and / or children's coping" (20.3%) (see Table 2). Other goals mentioned were children's "improved emotional regulation" (15.3%) and "improved school functioning" (11.9%) and "improved parenting skills" and "self-development in children" (6.8%). Families reported an average of 1.6 goals.

Regarding self-reported goal attainment, 64.9% of the respondents reported their goal(s) as having been met (54.4%) or partly met (10.5%),

TABLE 2
Chi-Square Results of Respondents' Reported Goals and Goal Attainment (N = 49)

Respondent's Reported Goals	Frequency (%) (N = 59)	Percentage of Goal Attained with Reference to Self-Reported Goals* (N)
Improved family relationship	44.1	56.5 (23)
Improved behavior at home	37.3	61.1 (18)
Self-development in parents	22.0	72.7 (11)
Improved parents' marital situation and / or children's coping	20.3	75.0 (12)
Improved emotional regulation	15.3	83.3 (6)
Improved school functioning	11.9	80.0 (5)
Self-development in children	6.8	66.7 (4)
Improved parenting skills	6.8	75.0 (4)

*Ten cases were discarded owing to missing information on goal attainment.

TABLE 3
Chi-Square Results of Helpful / Unhelpful Elements and Goal Attainment (N = 49)

Helpful / Unhelpful Elements in Therapy	Frequency (%) (N = 59)	Percentage of Goal Attained with Reference to Specific Helpful / Unhelpful Elements*	N
Helpful elements			
Being supported / validated	54.4	67.9	(28)
Useful feedback / educational	35.1	71.4	(14)
Focus on the positive and useful goals	33.3	68.8	(16)
Opportunity to talk	26.3	71.4	(14)
Good questioning helps thinking	26.3	69.2	(13)
Unhelpful elements			
Rigid, artificial, inflexible	5.3	0.0	(3)
Too positive	5.3	0.0	(3)
Insensitive, not being supported	5.3	33.3	(3)
Setting: camera, one-way mirror	5.3	33.3	(3)
Structural problems: timing, location	7.0	66.7	(3)

*Ten cases were discarded owing to missing information on goal attainment.

31.6% reported their goal(s) as not having been met, and 3.5% reported "unsure"; 83.6% of the respondents reported therapy as having been helpful overall.

With respect to the questions that explored what had been helpful in the therapy, the most often mentioned helpful element was the client's feeling of "being supported / validated" (54.4%), followed by "useful feedback or educational" (35.1%), "focus on the positive and useful goals" (33.3%), "opportunity to talk" (26.3%), and "good questioning helps thinking" (26.3%) (see Table 3).

There were fewer responses to the questions inquiring about what had been unhelpful in the therapy: 5.3% mentioned that the therapy had been "rigid, artificial, inflexible," "too positive," or "insensitive and not offering support" or that they had been "bothered by the one-way mirror, the camera, and the bug" (see Table 3).

Respondents' Reported Goals and Families' Presenting Problems

As stated above, solution-focused brief family therapy is concerned with finding solutions and gives minimal attention to problems. Since one can never know exactly what causes a problem, and both problems and solutions are subject to a person's construction and interpretation, the relationship between problems and solutions is not one to one. Goals, as such, need not be directly related to presenting problems. The present study explored the validity of this theoretical assumption for clinical practice.

An examination of the pattern of families' presenting problems and respondents' reported goals indicated that "family relationship problems" and "behavioral problems at home" were consistently the most frequently mentioned problems as well as goals to be achieved through therapy (see Tables 1 and 2). Inconsistency between families' presenting problems and respondents' reported goals was obvious for "children's emotional regulation problems" and "school-related problems." Despite the prevalence of these problems, they were not mentioned proportionately as goals to be attained through therapy. "School-related problems" were the second most frequently mentioned presenting problems (42.4%), although "improved school functioning" was the third least mentioned goal (11.9%). Likewise, 35.6% of the families mentioned "emotional regulation problems" as a presenting problem, but only 15.3% of the respondents reported "improved emotional regulation" as a goal (see Tables 1 and 2).

Instead, there was a tendency for parents to select goals focusing on themselves rather than on the problems. In fact, "self-development in parents" and "improvement in parents' marital situation and/or children's coping" were the third and the fourth most frequently mentioned goals, respectively (see Table 2). Both goals were parent focused in the sense that parents were the focus of change. Such a pattern may reflect the underlying assumptions of solution-focused brief family therapy, wherein the process is to help the families to develop useful and workable solutions that are not necessarily related to the problems (de Shazer et al., 1986).

Goal Attainment and Therapy Variables

To examine the relationship between goal attainment and various therapy variables, as well as children and family variables, only the data from respondents who answered either "yes" or "no" to the question "At the time treatment ended, was your goal met?" were included in the analysis. Responses from respondents who answered "Somewhat" or "Unsure" were excluded to eliminate any ambiguity in the analysis. Forty-nine cases were included in this analysis.

Goal Attainment and Families' Presenting Problems. Despite the deemphasis of solution-focused brief family therapy on problems, the findings indicated that goal attainment was significantly related to two presenting problems: "family relationship problems" ($p < .05$) and "children's emotional regulation problems" ($p < .05$) (see Table 1). Specifically, the absence of "family relationship problems" and the presence of "children's emotional regulation problems" were significantly related to positive goal attainment. Results indicated no significant association between the number of presenting problems and goal attainment.

Goal Attainment and Respondents' Reported Goals. For solution-focused brief family therapy, the focus is on setting useful goals and finding solutions rather than on the presenting problems (de Shazer, 1985, 1988; Walter & Peller, 1992). A useful research project, therefore, is to explore the relationship between the goals as reported by clients and their reported

goal attainment. Results indicated that there was no significant association between the respondents' reported goals and goal attainment (see Table 2).

Goal Attainment and Helpful or Unhelpful Elements of the Therapy Process. No significant association was found between helpful or unhelpful elements in the therapy process and goal attainment. The pattern of responses indicated that "being supported/validated" was the most frequently mentioned helpful element of therapy (54.4%). The frequencies for all other helpful elements were quite similar (around 30.0%) (see Table 3). Furthermore, there was consistently a higher percentage of those who mentioned a helpful element to have their goal met than those who had not mentioned the same element. Likewise, there was consistently a higher percentage of those who mentioned an unhelpful element to have their goal not met than those who had not mentioned the same element (see Table 3). However, the difference did not reach statistical significance.

With respect to the unhelpful elements of therapy, there were very few responses to this question. None of the respondents who mentioned unhelpful elements—such as "rigid, artificial, inflexible," or "too positive"—had their goals met (see Table 3).

Goal Attainment and Individuals Involved in the Therapy. Another useful question was whether goal attainment was related to who attended the therapy sessions and whether both parents' participation in the therapy was better than one parent's participation. These questions are especially relevant to solution-focused brief family therapy, which does not make the assumption that the participation of all involved family members is necessary for positive goal attainment (de Shazer & Berg, 1985). The therapist works with whoever is motivated to come. From a systems perspective, a small change in one person will bring about changes in the other members of the family. Findings from this study indicated that neither the number of family members involved nor who attended the therapy sessions was related to goal attainment. Also, the participation of one or both parents did not make a difference in terms of the client's goal attainment (see Table 4). Such findings still held true after the nature of the presenting problems was controlled for.

Goal Attainment and Children and Family Variables

Analyses were also performed for children's age, sex, family structure, parents' education, parents' occupation, and goal attainment. Such an investigation is useful to examine whether solution-focused brief family therapy works equally effectively with all client populations (de Shazer et al., 1986). Findings from this study indicated that there was no significant relationship between children or family variables and goal attainment (see Table 5). In other words, solution-focused therapy works equally well with clients from diverse backgrounds.

DISCUSSION

Studies by the Brief Family Therapy Center in Milwaukee (de Shazer, 1991; de Shazer et al., 1986) have reported success rates ranging from 72%

TABLE 4
Chi-Square Results of Parents' Involvement and Goal Attainment (N = 49)

Presenting Problems	Percentage of Goal Attained*			
	Involving one parent	(N)	Involving both parents	(N)
Family relationship problems	55.0	(20)	33.3	(9)
School-related problems	66.7	(9)	62.5	(8)
Behavioral problems at home	66.7	(15)	40.0	(5)
Emotional regulation problems	100.0	(11)	100.0	(6)

*Ten cases were discarded owing to missing information on goal attainment.

to 80%. The present study achieved a comparable 64.9% success rate for an average of 5.5 therapy sessions over an average of 3.9 months during which the respondents reported their goals as having been met or partly met. The slightly lower success rate of this study was expected, because of the difference in the experience of the therapists at different institutions. In fact, the good success rate reported by clients in this study provides initial evidence that solution-focused therapy can be practiced by therapists with varying levels of experience and still generate a satisfactory outcome for the clients.

Findings from the present study also supported the practice of working with whoever comes to therapy, because positive goal attainment was not associated with either one or both parents' attending therapy sessions. Unlike several family therapy approaches (such as structural family therapy), in which the presence of the whole family or, at the least, the significant members of the family is assumed, solution-focused brief family therapy does not make such an assumption. Instead, such an approach works with any member who is motivated to come to therapy and assumes that a small change in one part of the family system will lead to changes in the other parts.

The fact that no significant difference was found between children or family variables and goal attainment further suggests that solution-focused brief family therapy could work equally effectively with boys and girls of different age groups who live in diverse family constellations and have parents from different socioeconomic strata. Differences in major demographic characteristics of clients present no barrier to the applicability of such an approach.

The analysis of therapy process variables, however, also introduces thought-provoking theoretical and practice concerns that are open to future inquiry.

The Importance of a Supportive Relationship Between Therapist and Client

Despite an explicit emphasis on the process of focusing on the positive, helping families to notice small differences in the desirable direction, finding exceptions to the complaint situation, and formulating useful and workable goals (de Shazer, 1985, 1988; de Shazer et al., 1986), such a focus may be more apparent to the therapists than to the families. In fact, "being

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TABLE 5
Chi-Square Results of Client's Demographic Profile and Goal Attainment (N = 49)

Demographic Characteristics	Percentage of Goal Attained	N*
Age of Children		
4–6	85.7	(7)
7–11	58.8	(17)
12–13	58.3	(12)
14–16	60.0	(10)
17–18	66.7	(3)
Sex of Children		
Male	64.7	(31)
Female	60.0	(18)
Family Structure		
One-parent families	60.0	(15)
Two-parent families	70.4	(27)
Blended families	42.9	(7)
Mothers' Education		
High school	80.0	(10)
College / university	61.9	(21)
Postgraduate	75.0	(4)
Fathers' Education		
High school	80.0	(10)
College / university	61.9	(17)
Postgraduate	75.0	(5)
Mothers' Occupation		
Professionals	81.8	(11)
Managers, administrators	55.0	(20)
Service workers	62.5	(8)
Fathers' Occupation		
Professionals	66.7	(12)
Managers, administrators	55.6	(9)
Service workers	50.0	(6)

*Ten cases were discarded owing to missing information on goal attainment.

supported / validated" was the most frequently mentioned helpful element. Such a finding, however, is consistent with many other studies indicating that the support and validation that clients receive from therapists are two of the most important and fundamental elements of therapy (Rounsaville et al., 1987). Rigid adherence to techniques can be perceived as the therapist's being inflexible, rigid, too positive, artificial, and / or insensitive—all negatively related to goal attainment. In fact, none of the respondents in this study who described the therapist as "too positive"

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or "rigid, artificial, and inflexible" had their goals met (see Table 3). Such findings support the observation of some clinicians that "rushing to be brief" (Lipchik, 1994) or "forcing solution" (Nylund & Corsiglia, 1994) is detrimental to the therapy process.

Influence of Presenting Problems and Goals on Goal Attainment

Respondents' reported goals were not related to the therapy outcomes as indicated by self-reported goal attainment. However, the presenting problems of "family relationship problems" and "children's emotional regulation problems" were found to be significantly related to goal attainment; the former problem was associated with negative goal attainment and the latter with positive goal attainment. Despite a theoretical and clinical focus on finding useful solutions and deemphasizing problem talk, findings from the study provided some evidence that the nature of presenting problems still had an important influence on goal attainment that should not be totally neglected.

The pattern of distribution indicated that both presenting problems and goals related to "children's emotional regulation" and "school-related issues" had the highest percentage of goal attainment. In contrast, both presenting problems and goals related to "family relationship problems" had the lowest percentage of goal attainment (see Tables 1 and 2). It should be noted that more families reported problems and goals related to "family relationship problems" than problems and goals related to "children's emotional regulation" and "school-related issues." Still, a useful question to explore is why solution-focused brief family therapy appears to be quite useful for the former but not for the latter problems and goals. One possible explanation is that solution-focused brief family therapy tends to focus on setting a goal for a specific issue that can be indicated by small behavioral changes. Children's emotional regulation problems and school problems are specific, child-focused problems. Family relationship issues, on the other hand, are likely to be more complex and include more dynamics among different subsystems in the family. Future investigations are certainly needed to explain this phenomenon. Such a finding, nevertheless, raises questions about clinical practice with families who construe their problems or goals around family relationship issues. A question relevant to the practice orientation of solution-focused brief family therapy is: how can therapists assist clients to think in terms of concrete, small, and observable behavior when they construct their problems or goals around family relationship issues?

Relative Neglect of Goals on Children's Emotions and School Issues

Despite the high prevalence of "school-related issues" (42.4%) and "children's emotional regulation" (35.6%) as presenting problems, there was a lack of self-reported goals in these two areas. Such a pattern may indicate a tendency for parents to focus on children's behavior instead of their emotional development and to focus on children's behavior at home

instead of at school. However, such a focus may also indicate parents' relative lack of knowledge in the areas of children's emotional regulation and school-related issues. Parents may be pragmatic in choosing goals that focus on their children's familiar, observable behavior at home rather than choosing more unfamiliar goals focusing on their children's underlying emotions or an "outside" school system. Of interest is that respondents' reported goals related to "children's emotional regulation" and "school-related issues" had the highest percentage of goal attainment. Besides carrying out investigations to explain such a pattern of goal selection, children's mental health professionals may need to pay more attention to those neglected areas that appear to have a good potential of positive goal attainment.

CONCLUSIONS

This article reports the findings of an outcome study conducted by the Brief Family Therapy Team at the C. M. Hincks Centre in Toronto. About two-thirds of the families reported goal attainment within an average of 5.5 sessions—a result that provides initial evidence for the effectiveness of such an approach for helping families in a children's mental health agency. Because of the limitations in the research design, definitive conclusions about the effectiveness of such an approach cannot be reached. Nevertheless, the study was useful in providing data regarding respondents' evaluation of solution-focused brief family therapy with respect to goal attainment, the therapy process, and overall satisfaction with the service. In addition, findings from the study provide initial support for the applicability of solution-focused brief family therapy to a wide range of families from diverse backgrounds as well as for the practice of working with whoever comes to therapy.

The study also raises important issues regarding the theoretical and practice orientations of solution-focused brief family therapy. Further investigation regarding the helpful and unhelpful therapy process perceived by the families, and the influence of problem nature and goals on goal attainment, is needed for a more scientific and refined understanding of solution-focused brief family therapy.

To investigate the effectiveness of such an approach and to understand its change process, a more rigorous research design will be needed. Echoing the concerns raised by Kirby & Smyrnios (1990), specific recommendations for future investigations will include employment of appropriate control groups (alternative treatment methods), use of a larger sample for more precise and refined statistical analysis, specification of therapeutic techniques and standardizing treatment conditions, use of multiple reporting sources, and inclusion of objective as well as subjective baseline and outcome measurements.

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Spring 1997

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